STATUS REPORT:

Research and Demonstrations in Health Care Financing

Department of Health and Human Services
Health Care Financing Administration
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April 1983

Inpatient General

Interregional Differences in Hospital Utilization: A Source of Hospital Costs

Project No.:	18-P-97699/2-01
Period:	January 1981 - January 1982
Funding:	$ 65,821
Grantee:	Graduate School of Public Health New York University New York, N.Y.
Project Officer:	Paul Eggers Division of Beneficiary Studies

Description: This study examines regional differences in hospital discharge rates, average length of stay, and days of care rates. Using data from the Health Interview Survey, a multivariate analysis is performed to determine the relative importance of demographic characteristics and characteristics of the health care system in determining utilization rates. Specific analyses center on differences between the New York and Los Angeles standard metropolitan statistical areas.

Status: This study has been completed. The products are:

- "Variations in Hospital Use Across Cities: A Comparison of Utilization Rates in New York and Los Angeles" in Regional Variations in Hospital Use: Geographic and Temporal Patterns of Care in the United States, David Rothberg (ed), Lexington Press, 1981.

- Final Report - "Hospital Utilization: Reasons for Regional Differences Between the East and the West." National Technical Information Service, Accession No. PB3 167304.

Valid and Reliable Measurement of Inappropriate Hospital Utilization

Project No.:	HCFA 500-80-0053
Period:	June 1980 - July 1983
Funding:	$ 765,860
Contractor:	SysteMetrics, Inc. Bethesda, Md.
Project Officer:	Sherry A. Terrell Division of Beneficiary Studies

Description: The purpose of this project is to study inefficient acute care hospital utilization. The study has two components:

- The development of a methodology for measuring inappropriate hospital utilization.

- The application of the method in a national study to estimate the magnitude of inappropriate utilization and to identify likely causal factors. A (patient) chart review methodology was applied in 253 general acute care hospitals across the United States. Estimates of inappropriate admissions and days of care are being developed.

Status: This project is nearing completion. All developmental activity and field work are complete. A data set has been developed and data analysis is in progress. A final report is in preparation and is expected by mid-1983.

Hospital Costs and the Reduction of Excess Hospital Capacity

Project No.:	95-P-97526/5-02
Period:	December 1979 - March 1984
Funding:	$ 270,000
Grantee:	Michigan Office of Health and Medical Affairs Lansing, Mich.
Project Officer:	Joe Cramer Division of Hospital Experimentation

Description: This project grew from the concerns of labor and industry organizations involved in paying for medical care. By eliminating excess hospital beds, health care costs could be reduced. A Governor's task force was formed to address the financial, legal, and employment-related issues involved in hospital closures. Legislation was passed to require the development of bed-reduction plans. It is anticipated that 3,800 acute care hospital beds will be eliminated over the life of the program. Under the demonstration, the Michigan Hospital Capacity Reduction Corporation will review proposals from hospitals and approve specific reimbursement waivers related to capacity reduction activities. All third-party payers are expected to participate.

Status: Six health systems agencies with excess beds developed hospital-specific, bed-reduction plans that are updated on an ongoing basis. A Hospital Capacity Reduction Corporation was established in January 1981 to facilitate hospital capacity reduction. The Health Care Financing Administration is currently reviewing Michigan's latest request for waivers of selected Medicare reimbursement policies to facilitate hospital capacity reduction.

Outpatient

Physician and Other Ambulatory Services in Hospitals: Costs and Determinants

Project No.: 18-P-97880/5
Period: April 1981 - September 1983
Funding: $ 348,318
Grantee: American Hospital Association
Chicago, Ill.
Project Officer: Peter McMenamin
Division of Reimbursement Studies

Description: This ambulatory care project involves the collection and analysis of a large and significant data set that is expected to be the first in a recurring survey of hospital ambulatory care. The analysis is expected to provide a context for better understanding of the costs of hospital-based ambulatory care. The data will facilitate describing and monitoring costs of services in hospital outpatient departments.

Status: The American Hospital Association's first major submission under this grant was the refined analytical design submitted in October 1981. The survey design required several iterations because outpatient department cost data is not typically recorded in disaggregate detail by most hospitals. Surveying began in November 1982. Special followup efforts to enhance response rates have been prepared for public hospitals, urban hospitals, teaching hospitals, and hospitals with more than 300 beds.

Effect of Medicaid Reimbursement Rates on Use of Physician Services and on Hospital Outpatient and Emergency Room Care

Project No.: 18-P-97516/3
Period: September 1979 - December 1982
Funding: $ 413,378
Grantee: Urban Institute
Washington, D.C.
Project Officer: Peter McMenamin
Division of Reimbursement Studies

Description: This grant has examined the influence of reimbursement practices on access to ambulatory care, on the settings in which ambulatory care is provided, and on rates of hospitalization of Medicaid beneficiaries. The study analyzes 3 years of California Medicaid data covering periods both before and after a change in the California reimbursement system that changed relative fees in favor of primary care services.

Status: The study has yielded several important findings, the primary being that following the shift in physician fees, beneficiary access to care increased. Holding other things constant, however, the fee increase seems to have increased the probability of beneficiary hospitalizations. Nearly concomitant with the physician fee increase was an additional increase in fees for physician services performed in

outpatient departments. The two separate interventions yielded mixed results in terms of outpatient department utilization. Comparisons of total costs for patients whose predominant source of care was an outpatient department with those patients seen in physician offices show only small differences.

Relationship of Physician Medicaid Reimbursement in Private Practice and Hospital Outpatient Departments to Actual Costs of Providing Care

Project No.: 18-P-9705/1-02
Period: January 1981 - January 1983
Funding: $ 224,022
Grantee: Brandeis University
Florence Heller Graduate School
Waltham, Mass.
Project Officer: James Vertrees
Division of Reimbursement Studies

Description: This study compares the mix and cost of patients treated in hospital outpatient departments with those treated in private physicians' offices. It attempts to determine the extent to which presenting diagnoses differ in these settings and the extent to which those differences generate costs in one type of setting that substantially differ from those in others.

Status: The project has been completed. An article was published in the Health Care Financing Review, Vol. 4, No. 1, September 1982. The final report is expected in Spring 1983. The principle finding was that outpatient departments only had a slightly higher visit mix than private practice settings.

Comparison of Services by Hospital Outpatient Departments and Physicians' Offices

Project No.: 500-82-0018
Period: June 1982 - February 1983
Funding: $ 177,872
Contractor: Mandex, Inc.
Vienna, Va.
Project Officer: Benson Dutton
Division of Reimbursement Studies

Description: Title XXI, Section 2142 of Public Law 97-35 (The Omnibus Budget Reconciliation Act of 1981), instructs the Secretary to issue regulations that limit reimbursements to hospitals for outpatient services. In addition, the regulations must limit reasonable costs for outpatient services to reasonable charges for similar services delivered by area physicians in their offices. The Office of Research and Demonstrations awarded a contract to Mandex, Inc., to develop a method for complying with Section 2142. Mandex proposed using data from four states as a basis for their project. The States (Maryland, New Jersey, South Carolina and Florida) present a cross-section of intermediary and carrier operations. Intermediaries act as fiscal agents for Medicare Part A (hospital insurance) services. Carriers reimburse physicians and beneficiaries for Part B (supplementary medical insurance) services.

Status: The final report was submitted in February 1983. Selected findings include:

- Physicians' charges for the same procedure tended to be lower, more often than higher or the same, when provided in hospital outpatient departments.
- Charges by the same physician tended to be lower when the procedure was provided in an outpatient setting.
- The vast majority of physicians perform these individual procedures only once or twice in each setting.

Prospective Payment

Finger Lakes Area Hospitals' Corporation

Project No.: 95-P-97877/2-01
Period: January 1981 - December 1983
Grantee: Finger Lakes Area Hospitals' Corporation
Geneva, N.Y.
Project Officer: Vic McVicker
Division of Hospital Experimentation

Description: The Finger Lakes Area Hospitals' Corporation (FLAHC) is a test of whether an areawide budget system will be effective in controlling hospital costs in a rural area and whether local decisionmaking can effectively allocate financial resources between hospitals to cover the cost of new services. This 3-year project which includes all third-party payers (Medicare, Medicaid, and Blue Cross) was initiated January 1981, and includes eight hospitals in the rural Finger Lakes area of New York. The FLAHC payment program places an upper limit or cap on the total revenue paid to the community's hospitals for all patient care. Each participating hospital's revenue for 3 years is guaranteed at a base level, calculated primarily from the hospital's 1979 costs, trended forward to reflect inflation. In addition, a 2-percent contingency fund is administered by FLAHC to pay for increased hospital services and new and improved medical technology, and to provide working capital for participating hospitals. The contract has an option to be extended for 2 additional years.

Status: The demonstration has been operating relatively smoothly. However, the small rural hospitals are having some trouble with the system since a hospital budget is not automatically adjusted for items such as case-mix changes caused by the loss or addition of physicians in the area.

Evaluation of Nine Prospective Reimbursement and State Rate-Setting Programs

Project No.: 500-78-0036
Period: August 1978 - August 1983
Funding: $ 4,462,237
Contractor: Abt Associates, Inc.
Cambridge, Mass.
Project Officer: Richard Yaffe
Office of Demonstrations and Evaluations

Description: This is the evaluation of the impact of 15 hospital prospective reimbursement programs from 1970 to 1979. The study focuses on the following eight areas:

- Cost/Revenue/Financial Viability
- Volume and Composition of Services
- Staffing and Labor Cost
- Quality of Care and Ancillary Intensity
- Capital Formation and Closure/Merge Rates
- Organization and Management
- Accessibility of Care
- Systemwide Cost and Utilization

Status: The final results for each of the above listed areas will become available during the next several months. An integrated final report is expected by August 1983.

Incentive Prospective Payment System for Hospitals Through Fiscal Intermediaries

Project No.: 95-P-98199/1-01
Period: September 1982 - September 1986
Grantee: Massachusetts Hospital Association
Burlington, Mass.
Project Officer: Diane L. Rogler
Division of Hospital Experimentation

Description: This is a Statewide all payer prospective hospital reimbursement project proposed to Medicare by the Massachusetts Hospital Association and administered by Medicare's fiscal intermediaries. The waiver award was made with the condition that Medicare expenditures in Massachusetts be capped at 1.5 percent less than the national average rate of increase. If total hospital costs rise less than that amount, the hospitals will share in half of the savings. The methodology utilizes a "maximum allowable cost" developed from 1981 base year costs which are adjusted annually for inflation, volume changes, and certain other exceptions. Each year the amount paid to hospitals is reduced by a 2-percent productivity factor. The Massachusetts Rate Setting Commission approves each hospital's gross patient service revenue and provides an oversight function.

Status: Implementation of the project began October 1, 1982. Currently, charges and payments from Blue Cross, Medicare, and Medicaid are based on the maximum allowable cost methodology.

Rochester Area Hospitals' Corporation

Project No.: 95-P-97501/2-02
Period: January 1980 - December 1984
Grantee: State of New York
Albany, N.Y.
Rochester Area Hospitals' Corporation
Rochester, N.Y.
Project Officer: Vic McVicker
Division of Hospital Experimentation

Description: The Rochester Area Hospitals' Corporation (RAHC) Hospital Experimental Payment Program is a test of whether an areawide budget system will be effective in controlling hospital costs in a metropolitan area and whether local decisionmaking can effectively allocate financial resources between hospitals to cover the cost of new services. This 5-year project which includes all third-party payers (Medicare, Medicaid, and Blue Cross) was initiated January 1, 1980 and includes nine hospitals in the Rochester area of New York. The Hospital Experimental Payment program places an upper limit or cap on the total revenue paid to the community's hospitals for all patient care. Each participating hospital's revenue for 5 years is guaranteed at a base level, calculated primarily from the hospital's 1978 costs, trended forward to reflect inflation. In addition, a 2-percent contingency fund is administered by RAHC to pay for increased hospital services and new and improved medical technology, and to provide working capital for participating hospitals.

Status: Based on an assessment of the first 3 years of operation, the hospitals and payers agreed to maintain the system for the entire 5-year test.

Prospective Reimbursement System Based on Patient Case-Mix for New Jersey Hospitals

Project No.: 600-77-0022
Period: December 1976 - December 1983
Funding: $ 4,912,802
Contractor: New Jersey State Department of Health
Trenton, N.J.
Project Officer: Cynthia K. Mason
Division of Hospital Experimentation

Description: This project is testing a prospective payment system based upon diagnosis related groups (DRGs). Each DRG contains diagnoses that require similar levels of resource consumption. Hospitals retain any savings if costs are less than the DRG rates, but they assume liability if expenditures are greater. All general acute care hospitals in the State are required to participate and the system is applicable to all patients as well as third-party payers.

Status: All general acute care hospitals were phased into the system over a 3-year period that ended December 1, 1982. Over the course of the demonstration, the State has been successful in overcoming many of the billing and data problems associated

with a per-case payment system and indications are that the system has had a positive effect upon the management of hospital resources in the State.

Proposal for the Development of a Hospital Reimbursement Methodology for New York State for the 1980's

Project No.: 95-P-98216/2-01
Period: January 1983 - December 1985
Grantee: State of New York Department of Health
Albany, N.Y.
Project Officer: Joe Cramer
Division of Hospital Experimentation

Description: The project is a test of a prospective per diem payment system for all payers in the State. Under this 3-year proposal, rates are determined using 1981 costs as the base. Base year allowable costs are calculated through the use of peer group comparisons with ceilings on ancillary costs and a combined routine cost/length of stay ceiling. Once allowable costs are determined, rates for 1983 are calculated by inflating the costs by a trend factor. In 1984 and 1985, a "rate-to-rate" methodology is applied. The system provides for the establishment of bad debt and charity care pools on a regional basis to be supported by the payers.

Status: Effective January 1, 1983, all short-term general hospitals are being paid under the system.

Prospective Payment System for Acute and Chronic Care Hospitals in Maryland

Project No.: 500-80-0044
Period: June 1980 - September 1983
Funding: $ 2,037,563
Contractor: Maryland Health Services Cost Review Commission
Baltimore, Md.
Project Officer: Albert W. Jones
Division of Hospital Experimentation

Description: This project is testing the long-term effects of an all-payer, Statewide hospital prospective payment system in Maryland. The Maryland Project uses a public utility commission's approach to hospital rate regulation. The Maryland Health Services Cost Review Commission established hospital rates and then adjusted them for such items as inflation, volume changes, and pass-through costs. Currently, Maryland employs three separate systems: a detailed budget review system for individual hospitals; an automatic annual inflation adjustment for individual hospitals without a total budget review; and a payment system based on diagnosis, the Guaranteed Inpatient Revenue system. The Maryland Health Services Cost Review Commission will continue to refine the present prospective payment system to include case mix for small hospitals, and extend its activities into additional areas of health services review and payment (e.g., ambulatory and chronic care) while trying to keep the rate of increase in hospital costs below the national average.

Status: The current Medicare and Medicaid waivers will terminate June 30, 1983; however, the Maryland Commission will seek to have the waivers continued under Section 903 of the Omnibus Reconciliation Act of 1981. A final report is expected by October 1983.

Case Mix

Development of Diagnosis-Related Groups Using ICD-9-CM Codes

Project No.: 95-P-97499/1-02
Period: September 1979 - December 1981
Funding: $ 600,094
Grantee: Yale University
New Haven, Conn.
Project Officer: Julian Pettengill
Division of Reimbursement Studies

Description: Diagnosis related groups were developed using the International Classification of Diseases, 9th Revision, Clinical Modification data, and based on attributes available on standard patient abstracts. Patient classes were formed that have similar clinical and resource consumption patterns.

Status: The project has been completed and yielded five interim reports, a final report, and accompanying software that describes the development of the diagnosis-related group classification scheme and its Medicare Provider Analysis and Review (MEDPAR) version. The final report is being processed for publication under the Office of Research and Demonstrations Grants and Contracts Report series.

An Examination of the Case-Mix Length of Stay, Costs, and Reimbursement of Rural Hospitals

Project No.: 18-P-97703/702
Period: September 1980 - September 1982
Funding: $ 184,318
Grantee: University of Iowa
Graduate Program in Hospital and Health
Iowa City, Iowa
Project Officer: James Vertrees
Division of Reimbursement Studies

Description: This research examined the performance of rural hospitals with an interest in determining the influence of case-mix, patient referral patterns, and Medicare utilization on the costs, length of stays, and reimbursement in hospitals. The study examined discharge data using auto-group case-mix methodology.

Status: The final report is expected in Spring 1983. Preliminary results indicate that rural hospitals transfer many of their more complex cases to urban hospitals.

Measuring the Cost of Case Mix Using Patient Management Algorithms

Project No.: 18-P-97063/3-05
Period: September 1978 - September 1983
Funding: $ 1,166,846
Grantee: Blue Cross of Western Pennsylvania
Pittsburgh, Pa.
Project Officer: Julian Pettengill
Division of Reimbursement Studies

Description: This project will develop and test a case-type classification system for output measurement and hospital classification using clinical management criteria and category weights based on cost. This research is developing relative weights for the categories based on the services that clinicians believe typical patients should receive. It is also developing the capability to calculate alternative weights based on the services that the average patient actually receives as indicated by billed charges.

Status: The case-type definitions are virtually complete. Final categories, expected treatment cost estimates for each category, and an evaluation of the system are expected in Fall 1983.

Data Development and Analyses

Automated Hospital Information Systems: Development of Evaluation Methods

Project No.: 18-P-97925/9-02
Period: January 1981 - April 1984
Funding: $ 464,657
Grantee: Lutheran Hospital Society of Southern California
Los Angeles, Calif.
Project Officer: William Damrosch
Division of Hospital Experimentation

Description: This 4-year project examines the ramifications of using various types of automated hospital information systems within the hospital. The sponsor is developing a methodology for establishing a cost-benefit analysis for the types of systems to be installed in various hospital settings. A manual will be developed to enable hospitals to make their own informed judgements about the installation of an automated hospital information system.

Status: The project is currently field testing parts of the manual. Several refinements are being considered and a computerized evaluation package is being prepared.

Data for Hospital Cost Monitoring and Analysis of Hospital Costs

Project No.: 500-80-0066
Period: September 1980 - December 1983
Funding: $ 759,800
Contractor: American Hospital Association
Chicago, Ill.
Project Officer: J. Michael Fitzmaurice
Division of Reimbursement Studies

Description: This project obtains survey data from a set of hospitals that are surveyed monthly about their costs and activities. This serves as a prime source of outside data on the performance of hospitals and is used in Health Care Financing Administration (HCFA) analyses, research, and publications.

Status: To date, HCFA has received monthly "National Hospital Panel Survey Reports" and monthly "Community Hospital Statistics" through September 1982. The data are available in both hard copy and computer tape format.

Maryland Integrated Data System

Project No.: 18-P-98003/3-01
Period: August 1981 - March 1983
Funding: $ 109,000
Grantee: Maryland Health Services Cost Review Commission
Baltimore, Md.
Project Officer: William Damrosch
Division of Hospital Experimentation

Description: This 1-year project examines ways to merge cost, billing, and discharge data for Maryland hospitals. The focus of this project is to decrease the error rate and improve the turnaround time on corrections, particularly on diagnostic data. The ultimate aim is to have the Maryland Health Services Cost Review Commission function as the data service bureau for State and local agencies as well as other data users.

Status: This integrated data demonstrations was ended sooner than planned because of budget restrictions. The project was given a no-cost extension until March 31, 1983, to allow completion of the first year's work under this curtailed grant.

Statistical and Analytical Services to Support Provider Reimbursement Studies

Project No.: 500-78-0041
Period: September 1978 - June 1983
Funding: $ 1,505,000
Contractor: Applied Management Sciences
Silver Spring, Md.
Project Officer: J. Michael Fitzmaurice
Division of Reimbursement Studies

Description: This is a project to provide statistical and analytical support for hospital cost inflation studies and simulations, as well as to conduct a number of independent investigations, including analysis of the influence of various payment systems on hospital costs. The project will also analyze hospital department cost/charge ratios and the relation between hospital overhead allocation and revenue for revenue-producing centers.

Status: Two final reports have been delivered to the Health Care Financing Administration in 1982. The first report, "An Evaluation of the Effectiveness of the Section 223 Limits," May 1982, revealed for a sample of hospitals that:

- Hospitals with more Medicare patients appear more likely to attempt to restrain costs, possibly to avoid substantial penalties under the Section 223 limits. (While these hospitals tend to have lower routine costs per patient day, they have had faster increases in the levels of routine costs per day over the 3 years of the study.)

- Small hospitals have a greater likelihood of a loss under the Section 223 limits.

- Teaching hospitals and hospitals with more difficult cases are more likely to be penalized by the limits.

- Hospital located in the North Central and South regions have lower likelihoods of incurring a loss than hospitals located in the Northeast and West regions.

In the second report, "Analysis of Interest Income on Funded Depreciation," November 1982, although there were substantial problems with the quantity and quality of hospital reporting, some tentative findings are suggested. If interest income from funded depreciation were to be subtracted from interest expense before Medicare reimbursement of interest expense, nonprofit hospitals would be more heavily affected by this policy than other hospitals.

Studies of Hospital Cost Inflation

Project No.: 18-P-97090/4-03
Period: September 1978 - June 1982
Funding: $ 260,771
Grantee: Vanderbilt University
Nashville, Tenn.
Project Officer: J. Michael Fitzmaurice
Division of Reimbursement Studies

Description: This study examined the roles of the physician market and hospital medical staff characteristics on hospital cost inflation and analysis of potential inflationary effects of hospital wage rates because of the growth of hospital unionization.

Status: This project was completed in 1982. Thirteen papers resulted from this study. Some of the findings are:

- Type of physician compensation (salary, percent of gross revenue, etc.) is of minor consequence in explaining the increase in hospital costs or the variation of costs among hospitals.

- No evidence that investor-owned hospitals are less expensive than those of other ownership was found. However, the investor-owned hospitals were similar to comparable nonprofit hospitals with respect to profitability and the proportion of patients on Medicaid.

- The "best" estimate was that unions raise hospital employee wages by approximately 6 percent for registered nurses and 10 percent for nonprofessionals.

- Mandatory rate-setting programs tend to reduce earnings at the bottom of the wage scale when the occupation is not unionized, with little effect at the top of the scale.

- Mandatory rate-setting programs in effect for more than 3 years are estimated to reduce hospitals costs per adjusted patient day and per admission by about 3-4 percent a year up to approximately 20 percent when the program reaches an equilibrium situation.

- Certificate of need shows no effect on hospital costs.

Financially Troubled Hospitals

Bedford-Stuyvesant/Crown Heights Demonstration Project

Project No:	95-P-97605/2-03
Period:	November 1979 - May 1983
Grantee:	New York State Department of Social Services Albany, N.Y.
Project Officer:	Rose M. Truax Division of Hospital Experimentation

Description: The goal of the project was to achieve fundamental changes in the health care delivery system in the project catchment area. This 4-year demonstration project tests new reimbursement strategies formulated to provide for Federal coverage of a proportionate share of uncompensated care costs. The project tests whether financial stability promotes a reconfiguration of the delivery system and subsequent viability.

Status: System changes as part of the project were:

- Consolidation of the nonemergency ambulatory care currently provided by the hospitals under a separate corporation. (Certificate-of-Need application submitted October 1981.)

- Consolidation at Jewish Hospital and Medical Center of Brooklyn (JHMCB) of the obstetrical services currently provided by this hospital and St. John's. (Application submitted September 1981.)

- Full merger of JHMCB and St. John's with a combined reduction in beds of 245, from 945 to 700. (Application submitted May 1982 - beds since reduced to 650 complement.)

The merger application was approved by the New York State Public Health Council on for November 19, 1982, thus completing the State approval process. A 6-month extension of the project was granted for November 26, 1982 through May 27, 1983 to facilitate the transition to standard payment methods.

Metropolitan Comprehensive Care Program: A Health Systems Organization Demonstration

Project No.: 11-P-97805/2-03
Period: September 1980 - September 1986
Grantee: New York State Department of Social Services
Albany, N.Y.
Project Officer: Rose M. Truax
Division of Hospital Experimentation

Description: The demonstration is designed to test a new financing and health care role for municipal hospitals. The demonstration is specifically targeted for the medically indigent and all other members of the East Harlem community. A 5-year study which is based at Metropolitan Hospital will provide coverage to a maximum of 17,100 poor and near-poor residents of the community who are ineligible for Medicaid coverage under existing Federal/State regulations. The five critical components of the demonstration are:

- The case management system.

- The reorganization of the hospital management and financial systems.

- The introduction of the Citycaid program.

- Improved screening for Medicaid, Citycaid and other third-party insurance.

- The establishment of a State qualified health maintenance organization (HMO).

Status: The focus of the first and second year activities has been establishing administrative mechanisms and implementing organizational changes to support a case-management approach to medical care for an enrolled population. The third year will focus on planning for the HMO. Enrollment levels have been growing (an estimated 800 persons enrolling per month) with a projected enrollment of 28,000 by October 1983.

Alternative Methodologies for Reimbursement and Delivery of Health Care Services to Inner City Poor

Project No.: 11-P-97863/1-03
Period: January 1981 - January 1984
Grantee: Massachusetts Department of Public Welfare
Boston, Mass.
Project Officer: Rose M. Truax
Division of Hospital Experimentation

Description: This 3-year demonstration project, the Boston Health Plan, tests the effectiveness of a case-management system in a network of Community Health Centers linked to an inner city hospital. Reimbursement is a prospective capitation method. The approach will demonstrate that:

- Financial viability can be achieved by the use of new "strategies" in the provision of patient care and methods of reimbursement.
- The hospital can serve as an effective case manager, reducing costs and improving health outcomes.

Status: The project became operational November 1, 1981, and six primary care centers were providing services by February 1983. The centers have enrolled 6,477 newly eligibles--999 city employees and 738 currently eligible Medicaid recipients. This is the third and last year of this project; the focus for the year will be the future of Boston Health Plan after the grant period.

Strategies to Improve the Financial Viability of the Urban Hospital

Project No.: 11-P-97866/4-03
Period: January 1981 - September 1984
Grantee: Florida Department of Health and Rehabilitative Services
Tallahassee, Fla.
Project Officer: Rose M. Truax
Division of Hospital Experimentation

Description: This 4-year demonstration project will test the feasibility of covering a medically needy population in Florida in a capitated primary care system. Enrollees will lock themselves into care at an urban hospital and its primary care center. The services provided are limited to inpatient, outpatient, physician services, and pharmacy. The approach will demonstrate that:

- Financial viability can be achieved by the use of new "strategies" in the provision of patient care and methods of reimbursement.
- The hospital can serve as an effective case manager, reducing costs and improving health outcomes.

Status: The project became operational October 1, 1981, with the opening of a new primary care center at the University Hospital of Jacksonville. There are approximately 15,000 enrollees at the center--6,000 newly eligible, 2,384 currently eligible Medicaid recipients, and approximately 6,616 self-pay.

A Proposal to Relieve Financial Distress at a Congested Urban Medical Center

Project No.: 11-P-97817/9-03
Period: January 1981 - January 1985
Grantee: California Department of Health Services
Sacramento, Calif.
Project Officer: Rose M. Truax
Division of Hospital Experimentation

Description: This 4-year demonstration project tests the cost effectiveness of a county health maintenance system with capitated reimbursement for the medically indigent population served at the Los Angeles County/University of Southern California Medical Center and a community health care center. The approach will demonstrate that:

- Financial viability can be achieved by the use of new "strategies" in the provision of patient care and methods of reimbursement.
- The hospital can serve as an effective case manager, reducing costs and improving health outcomes.

Status: The first 2 years of this project has been a developmental phase. The project became operational February 1, 1983.

Other Hospital

Allocation of Resources Under the Budget Constraints Imposed by the British National Health Service

Project No.: 18-P-97647/3-02
Period: March 1980 - September 1982
Funding: $ 127,794
Grantee: The Brookings Institute
Washington, D.C.
Project Officer: J. Michael Fitzmaurice
Division of Reimbursement Studies

Description: The Brookings grant examines the way investment decisions are made when the British National Health Service limits expenditures for medical care. It will determine what fraction of the demand for several specific technologies was satisfied and why. The investigators visited Britain to gather epidemiological and expenditure data and information on the decisionmaking process of resource allocation.

Status: In the first year, the investigators added a survey of American and British physicians to the project and increased the planned length of their final report. It is

expected that a full-length book will result from this project in Fall 1983. It will show how restricting health expenditures in a particular area leads to substitutions of other and possibly less costly medical care treatments.

Paying the Hospital: Foreign Lessons for the United States

Project No.: 18-P-97363/2-03
Period: June 1979 - June 1982
Funding: $ 253,452
Grantee: Columbia University
New York, N.Y.
Project Officer: J. Michael Fitzmaurice
Division of Reimbursement Studies

Description: This study provided a systematic description of the methods of paying hospitals under National Health Insurance Programs in those major developed countries of Western Europe having experiences that are the most relevant to hospital cost containment in the United States. The countries under study were Great Britain, France, Switzerland, Holland, Canada, and Germany. The field research relied primarily on extensive interviews with persons involved with hospital finance.

Status: This study ended in 1982. Major reports for France, Holland, Switzerland, Canada, and Great Britain were submitted. Germany is discussed in the final report. The author's findings were:

- Standardization in payment procedures and the requirement to submit prospective budgets to regulators and negotiators lead to uniform reporting to all payers and public authorities in all countries.

- Costs are the basis of payment rates for nonprofit and public hospitals in every country, except those with top-down global budgeting.

- Payment rules, the units of payment, and definitions of allowable costs are generally the same for all payers.

A special report on this project will be published in the Summer 1983 issue of the Health Care Financing Review.

Data Development and Analyses

Analysis of Survey Data and Physician Practice Costs and Income: Physician Earnings and Return to Medical Training and Specialization

Project No.: 500-78-0054
Period: September 1978 - February 1983
Funding: $ 124,162
Contractor: Institute for Demographics and Economic Studies, Inc.
New Haven, Conn.
Project Officer: James Cantwell
Division of Reimbursement Studies

Description: The purpose of this project is to compute rates of return to medical education by specialty, comparing them with other occupations and assessing the impact on rates of return to various increases in medical education costs.

Status: A final report for this project is expected in Spring 1983. An early draft indicates that relative to other professionals, returns to medical education were substantial. In addition, between 1972 and 1977 the earnings of young incumbents in professional, technical, and managerial occupations declined, often substantially. The significant exceptions to this trend were physicians and other health professionals. Returns by specialty indicate that opthalmology, cardiology, and surgery were especially high-return specialties.

Alternative Methods for Describing Physicians' Services Performed and Billed

Project No.: 500-81-0054
Period: September 1981 - September 1983
Funding: $ 338,120
Contractor: Health Economics Research, Inc.
Chestnut Hill, Mass.
Project Officer: James Cantwell
Division of Reimbursement Studies

Description: This study will analyze the advantages and disadvantages of many different methods of combining or packaging physician services for reporting and billing purposes. This will include analysis of the extent to which current Medicare billing procedures, Current Procedural Terminology (CPT-4), may foster unpackaging. The project will also develop and test new ways of packaging physician services for reimbursement purposes, particularly the feasibility of using medical criteria such as diagnosis and reason-for-visit.

Status: In October 1982, the first year report was received. This report included:

- A discussion of types of packages.
- Evaluation criteria.

- Predicted physician responses.

- A discussion of office visit packages.

Demonstration of Integrated Data System to Promote Cost Containment Among Primary Care MD's

Project No.: 18-P-97538
Period: September 1980 - October 1982
Funding: $ 498,600
Grantee: Dartmouth University
Hanover, N.H.
Project Officer: William Sobaski
Division of Reimbursement Studies

Description: This project's goal is to establish a network of freestanding primary care practices in New England to provide participating practices with accounting services and statistical information on their practices as compared with the total cooperative network's practices.

Status: A billing and management information system was installed in 35 practices. The project is continuing using other sources of funding.

Analysis of Physician Pricing Behavior, Third Party Administrative Practices

Project No.: 600-76-0058
Period: April 1976 - June 1983
Funding: $ 741,570
Contractor: Harvard University
Cambridge, Mass.
Project Officer: William Sobaski
Division of Reimbursement Studies

Description: This study deals with physician response to reimbursement alternatives, including analysis of price trends, relative values, and relations between medicine and private health insurance.

Status: All interim reports completed. Final report is expected in mid-1983.

- The study of price trends showed that wide disparities both within and across areas may be concealed by national price trend figures.

- A unique methodological approach to relative value studies was undertaken that showed large imbalances exist between payments for technological procedures versus primary care.

- The nonprofit and for-profit private insurance sectors were shown to employ quite different strategies in establishing relationships with medicine, albeit both cover positive relationships.

- A new model of supply-and-demand factor interactions in the medical market is being developed.

Aspects of Physician Behavior in Medicare and Medicaid

Project No.: 95-P-97178
Period: September 1978 - December 1983
Funding: $ 730,313
Grantee: The Urban Institute
Washington, D.C.
Project Officer: James Cantwell
Division of Reimbursement Studies

Description: This project examines three areas of physician reimbursement:

- Provision of pathology services.
- The effect of reimbursement on physician practice location.
- Simulation and analysis of alternative reimbursement systems.

Status: Work analyzing the effects of reimbursement on physician practice location, the Medicare Economic Index, and Medicare-Medicaid fee levels and differences have been completed. During the fifth year, two ongoing tasks will be completed and eight additional tasks involving simulations and behavioral modeling will be undertaken, using existing data files.

Alternative Methods for Developing a Relative Value Scale of Physician Fees

Project No.: 500-81-0053
Period: September 1981 - September 1983
Funding: $ 287,557
Contractor: The Urban Institute
Washington, D.C.
Project Officer: James Cantwell
Division of Reimbursement Studies

Description: This project explores criteria and methods underlying relative value scales for physician services. Some of these methods will be applied to approximately 100 procedures to develop relative value scales. The study will address the implications of adopting different construction methods.

Status: Five broad classes of approaches to developing relative value scales are discussed in the first year report, received in February 1983. These five classes of methods are charge-based, statistical cost function, time-based, micro costing, and group decisionmaking approaches.

Costs, Outcomes, and Competiton in the End-Stage Renal Disease Program

Project No.: 18-P-98056/3
Period: August 1981 - August 1983
Funding: $ 407,096
Grantee: The Urban Institute
Washington, D.C.
Project Officer: James Cantwell
Division of Reimbursement Studies

Description: This project will aid in the overall assessment of the End-Stage Renal Disease (ESRD) program by studying three aspects:

- The determinants of the total cost of the program.
- Some measures of the health outcomes produced by the program.
- Alternative ways of organizing and improving the services.

Particular attention will be given to the effects of competition on the cost and quality of care among facilities in an area.

Status: Two major papers have been produced thus far under this grant: "Pro Competitive Health Insurance Proposals and their Implications for the ESRD Program" and "Competition and Efficiency in the ESRD Program." The first paper concludes that there are numerous ways to induce more competitive behavior in the delivery of ESRD service, especially maintenance dialysis, although there are significant implementation problems with some strategies. The second paper concludes that analysis of cost alone cannot determine appropriate reimbursement levels, because that determination requires a prior political decision of the appropriate level of amenities.

Pricing Behavior of Pennsylvania Physicians Since 1970

Project No.: 500-80-0011
Period: January 1980 - February 1983
Funding: $ 49,271
Contractor: Pennsylvania Blue Shield
Camp Hill, Pa.
Project Officer: James Cantwell
Division of Reimbursement Studies

Description: This project funds the collection of data to study longitudinal changes in physician service pricing levels in Pennsylvania and their association with changes in practice and sociodemographic characteristics since 1970. The analysis of the data is funded under a separate contract (600-76-0146).

Status: This project was completed in December 1981. The project found substantial variation in fees charged by Pennsylvania physicians. There was clear evidence of differences in price between Medicare and Blue Shield programs. The simulation portions of the study found that Medicare aggregate program cost varied very little with changes in physician specialty or locality designations.

Other Physician Payment

Physician Reimbursement and Continuing Care under Medicaid Suffolk County, New York

Project No.: 11-P-98052/2-02
Period: September 1981 - December 1985
Funding: $ 618,593
Grantee: Department of Social Services
Albany, N.Y.
Project Officer: Sherrie Fried
Division of Health Systems and Special Studies

Description: This demonstration is designed to test the impact of alternative methods of physician reimbursement on the provision of continuing care for Medicaid children in Suffolk County, N. Y. The methods include the current fee schedule, a fee-for-service/continuing care method that reimburses physicians at a higher rate for accepting continuing comprehensive care, and a comprehensive prepayment plan.

Status: The project will begin the operational phase in Spring 1983. Major milestones include approval by the Health Care Financing Administration of the continuation request; development of capitation rates and an augmented fee schedule; and development of claim payment, data collection, and management reporting systems.

Studies in Physician Reimbursement

Project No.: 95-P-97309/2
Period: June 1979 - December 1982
Funding: $ 330,802
Grantee: Princeton University
Princeton, N.J.
Project Officer: Peter McMenamin
Division of Reimbursement Studies

Description: This study examined the role of fee schedules in physician reimbursment under third-party payment systems in Europe and Canada. Specific tasks included development of the conceptual basis for fee schedules and analytic frameworks for assessment of changes within them, as well as descriptive analyses of fee schedules and relative price structures in the United States.

Status: Several country-specific papers have been produced on physician fee determination systems. The paper on the French system was written by Simone Sandier of CREDOC, the French health economics research institute. The paper on the German physician fee system was written by the late Ulrich Geissler, and an excerpt from that paper will be published in the Summer 1983 issue of the Health Care Financing Review. Uwe Reinhardt's paper on the German health funds and negotiations under their system was published in the December 1981 issue of the Health Care Financing Review. Both the German and French systems have shown that uniform relative value schedules are possible; in fact, the French in effect have a nationwide fee schedule. The Germans have been trying to alter their relative value schedules to improve the relative position of primary care services, but as yet without much success.

Impact of Physician Supply and Regulation on Physician Fees and Utilization of Services

Project No.: 18-P-97619/5
Period: March 1980 - March 1983
Funding: $ 408,287
Grantee: Blue Cross/Blue Shield of Michigan
Detroit, Mich.
Project Officer: Peter McMenamin
Division of Reimbursement Studies

Description: Blue Cross and Blue Shield of Michigan (BCBSM) has used paid claims files to examine the issue of physician-induced demand. BCBSM has also examined market areas in Michigan with private and Medicare paid claims from 1975 to 1980. In addition, the study is investigating the impact of physician supply and regulation on the price and quantity of physician services. To supplement the paid claims data, BCBSM has surveyed a sample of Michigan physicians to determine amenities, workload/hours, non-Blue Shield volume and charges. This project will describe and analyze variation in per capita use across market areas. BCBSM is using patient illness diagnostic tracers from physician billing data. The inducement hypothesis is to be tested using a "Reinhardt test" of physicians' fees while holding relevant supply, demand, and amenities variables constant.

Status: The study identified 15 market areas in Michigan and showed that there were major differences between market areas in use rates as well as the growth in those rates. The areas with the highest use rates in 1975 were also the markets with the highest growth in use. On induced demand, the data support the hypothesis that an increase in the availability of doctors increases the use of services, but the evidence refutes the target income hypothesis by showing that fees move toward competitive levels. BCBSM interim reports were very useful in resolving the clinic locality issue in Michigan raised by Congressman Robert Davis (R-MI) in 1982. Other reports received include:

- "Medicare Assignment Rates in Michigan"
- "The Effects of Physician Availability on Fees and the Demand for Doctors' Services"
- "Survey of Michigan Physicians' Practice Characteristics"
- "Medicare Fees, Use, and Assignment Rates in Michigan's Physician Service Markets"
- "Fees or Use? What's Responsible for Rising Health Care Costs?"
- "The Determination of Medicare Market Areas and Medicare Fees, and Use in Michigan"

Skilled Nursing Facility Prospective Payment

Alternative Nursing Home Reimbursement Systems for Medicare

Project No.: 18-P-98274/3-01
Period: January 1983 - December 1983
Funding: $ 155,605
Grantee: The Urban Institute
Washington, D.C.
Project Officer: Philip Cotterill
Division of Economic Analysis

Description: This study will simulate alternative approaches to prospective payment for Medicare skilled nursing facilities (SNF's) and investigate administrative factors that affect the efficiency of patient-related rate payment systems. The study utilized Medicare SNF cost reports and Medicaid cost reports for 3,500 nursing homes in 10 States for the period 1978-80. The 10 States included in the study are: California, Connecticut, Georgia, Illinois, Maryland, Massachusetts, Minnesota, New York, Washington, and West Virginia.

Status: This project was initiated January 1, 1983.

New York State Capitation Payment System for Long-Term Care

Project No.: 11-P-98194/2-01
Period: March 1982 - March 1986
Funding: $ 688,184
Grantee: New York State Department of Social Services
Albany, N.Y.
Project Officer: Dennis M. Nugent
Division of Long-Term Care Experimentation

Description: The major problem to be addressed in this demonstration is the large number of Medicaid patients requiring a skilled nursing level of care who cannot be discharged from hospitals because of a shortage of nursing home beds. To relieve this situation, the Rochester Area Hospitals' Corporation is developing a capitation reimbursement system for more flexible and more cost-effective placement of these patients in subacute settings.

Status: This project is in the final phase of its developmental year. During this initial year, a Steering Committee was established to provide overall direction to the demonstration. Developmental activities will continue through June 1983, with implementation of the capitation payment system scheduled to begin July 1, 1983.

West Virginia Long-Term Care, Quality-Cost Control System

Project No.: 11-P-97149/4-03
Period: April 1980 - June 1983
Grantee: State of West Virginia, Department of Welfare
Charlestown, West Va.
Project Officer: Tom Kickham
Division of Long-Term Care Experimentation

Description: This project is designed to implement and evaluate a Medicaid long-term care prospective reimbursement system based on reimbursement for services needed by and provided to patients at a reasonable cost. The reimbursement system utilizes three components on which to set the facility rate: nursing services, operating costs, and capital investment.

Status: This project is currently in its third and final year. The tasks completed in the first 2 years included the design and implementation of uniform accounting and reporting procedures, definition of the Model Facility Standards, initial appraisals of all facilities, the evaluation of the appraisals, and the establishment of a rate of return.

Channeling

Methodology for Two National Surveys on Long-Term Care

Project No.: 100-80-0159
Period: September 1980 - March 1982
Funding: $ 1,626,397
Contractor: National Opinion Research Center
Chicago, Ill.
Project Officer: Allen Dobson
Office of Research

Description: This project was initiated for the purpose of designing a survey that would provide information about the total population of functionally limited persons requiring long-term care. Because these individuals may be found both in households and institutions, the survey was proposed for two parts--depending on the location of the individual.

Status: As a result of budget limitations, the project was cut back to a survey of elderly individuals in households (Project No. IAA-82-0159). The contract with the National Opinion Research Center was continued to provide a supplement to the shortened survey, which provided information on a sample of persons (caregivers) helping functionally limited individuals. The data for this survey has been collected and is being processed. There were 1,939 cases completed for the survey of caregivers.

Evaluation of Coordinated Community Oriented Long-Term Care Demonstration

Project No.: 500-80-0073
Period: September 1980 - December 1983
Funding: $ 1,999,980
Contractor: Berkeley Planning Associates
Berkeley, Calif.
Project Officer: Spike Duzor
Evaluative Studies Staff

Description: This long-term care project evaluates a series of demonstration projects on the delivery of coordinated community care services. The demonstrations test whether care tailored to a client's needs can preclude moving them out of the community or into expensive institutional care settings.

Status: The contractor has completed draft case studies for the participating projects. These case studies highlight the history and origin of the project, describe project organization, and operation issues. A final report is expected in December 1983 and will focus on quality of care and cost-effectiveness issues.

National Long-Term Care Channeling Demonstrations

Period: September 1980 - May 1985

Description: This is a major national research and demonstration program. It is a combined effort of three components in the Department of Health and Human Services: the Health Care Financing Administration (HCFA); the Office of the Assistant Secretary for Planning and Evaluation, Office of the Secretary; and the Administration on Aging, Office of Human Development Services. The program is testing whether and to what extent the long-term care needs of elderly impaired persons can be met in a cost-effective way through a community-based system of comprehensive needs assessment, care planning, and case management. These components are the core channeling services. Five of the projects were designated as "complex model projects." These projects alter the basic channeling model by adding three program elements under HCFA waivers: expanded Medicare and Medicaid service coverage, authorization to approve reimbursement for services, and limitations on per capita expenditures.

Project Nos.: 11-P-98211/4-01
HHS-100-80-0136
Funding: $ 932,896
Contractor/ Grantee: Florida Department of Health and Rehabilitative Services
Tallahassee, Fla.
Project Officer: William Saunders
Division of Long-Term Care Experimentation

Status: The Miami Jewish Home and Hospital for the Aged has been designated as the organization responsible for implementing the Florida project. This site has been selected as a complex model project. The project catchment area includes the City of Miami and several surrounding communities. The project began serving clients in May 1982. Currently, this site has more than 200 clients. The organization hopes to reach a caseload of 429 clients by the end of June 1983.

Project No.: HHS-100-80-0138
Funding: $ 700,000
Contractor: Kentucky Cabinet for Human Resources
Frankfort, Ky.
Project Officer: William Saunders
Division of Long-Term Care Experimentation

Status: The Kentucky Department for Social Services has been designated as the agency responsible for implementing the Kentucky project. This site has been selected as a basic model project. The project catchment area covers eight rural counties in eastern Kentucky. The project began serving clients in February 1982. Currently, this site has 140 clients. The department hopes to reach a caseload of 160 clients by the end of June 1983.

Project No.: HHS-100-80-0139
Funding: $ 609,839
Contractor: Maine Department of Human Services
Augusta, Maine
Project Officer: Leslie Saber
Division of Long-Term Care Experimentation

Status: The Maine demonstration site is a basic model project administered under a subcontract with Southern Maine Senior Citizens, Inc., an Area Agency on Aging in Portland. The 2-county catchment area, Cumberland and York Counties, covers 2,000 square miles. The project began serving clients in February 1982. Currently, the project has more than 120 clients in the active caseload. The project expects to reach an active caseload of 196 clients by the end of June 1983.

Project Nos.: 11-P-98210/1-01
HHS-100-80-0141
Funding: $ 1,657,617
Contractor/ Grantee: Massachusetts Department of Elder Affairs
Boston, Mass.
Project Officer: Leslie Saber
Division of Long-Term Care Experimentation

Status: The Massachusetts Channeling demonstration is a complex model site operated by Greater Lynn Senior Services. The catchment area includes Greater Lynn and the Beverly area. The project began serving clients in May 1982. Currently, the project has more than 140 active clients and expects to reach an active caseload of 300 clients by the end of June 1983. The project's major referral sources are the Visiting Nurse Association, hospitals, and the Greater Lynn Senior Services.

Project No.: 11-P-98213/2-01
Grantee: New York State Department of Social Services
Albany, N.Y.
Project Officer: Thomas M. Kickham
Division of Long-Term Care Experimentation

Status: The Rennselaer County Department for the Aging has been designated as the agency responsible for implementing the New York project. This site has been selected as a complex model project. The project catchment area is Rennselaer County, New York. The project began serving clients in May 1982. Currently, the site has approximately 100 clients. The project hopes to reach a caseload of 159 by the end of June 1983.

Project No.: 11-P-98209/5-01
Grantee: Ohio Department of Public Welfare
Columbus, Ohio
Project Officer: Thomas M. Kickham
Division of Long-Term Care Experimentation

Status: The Cuyahoga County Board Commissioners has been designated as the agency responsible for implementing the Ohio project. The project site is administered by the Western Reserve Area Agency on Aging. The project catchment area covers Cuyahoga County, which consists of the City of Cleveland and 59 suburbs. The project began serving clients in May 1982. Currently, the site had approximately 200 clients. The project hopes to reach a caseload of 354 clients by the end of June 1983.

Project Nos.: 11-P-98212/3-01
HHS-100-80-0146
Funding: $ 2,235,982
Contractor/ Grantee: Pennsylvania Department of Public Welfare
Harrisburg, Pa.
Project Officer: Leslie Saber
Division of Long-Term Care Experimentation

Status: The Pennsylvania Channeling project is operated through a subcontract with the Philadelphia Corporation for Aging. This site is a fully centralized complex model project site. The catchment area covers more than 129 sites and includes the city and county of Philadelphia. The project began serving clients in May 1982. Currently, the project has an active caseload of 350 clients. The project estimates that its active caseload will reach 500 clients by the end of June 1983. The major project referral sources are hospitals, senior centers, and home health agencies.

Community-Based Care

State Medicaid Hospice Demonstration

Period: October 1980 - March 1983

Description: Fourteen States were granted waivers to gather data on the cost, utilization, and quality of hospice care provided to Medicaid recipients having a life expectancy of 6 months or less. Under the auspice of the State, an array of home care services (including continuous nursing care, bereavement assessment and counseling, and respite care) is being provided at several sites. Inpatient hospice care is also available at some sites.

Status: The States are currently in the wind-down phase of the project, because active patient enrollment ceased October 1, 1982. Services to surviving patients who enrolled prior to October 1 are still being provided. Medicaid utilization during the first project year was far lower than expected. During the second year, utilization nearly doubled.

Project No.:	11-P-50233/9-02
Grantee:	Department of Health Services Sacramento, Calif.
Project Officer:	Teresa Schoen Division of Long-Term Care Experimentation

Project No.:	11-P-50237/8-02
Grantee:	Colorado Department of Social Services Denver, Colo.
Project Officer:	Dennis M. Nugent Division of Long-Term Care Experimentation

Project No.:	11-P-50255/1-02
Grantee:	Department of Income Maintenance Hartford, Conn.
Project Officer:	Patricia Talley Division of Long-Term Care Experimentation

Project No.:	11-P-50241/4-02
Grantee:	Department of Health and Rehabilitative Service Tallahassee, Fla.
Project Officer:	Patricia Talley Division of Long-Term Care Experimentation

Project No.:	11-P-50260/1-02
Grantee:	Department of Public Welfare Boston, Mass.
Project Officer:	Patricia Talley Division of Long-Term Care Experimentation

Project No.:	11-P-50226/5-02
Grantee:	Department of Public Welfare St. Paul, Minn.
Project Officer:	Dennis M. Nugent Division of Long-Term Care Experimentation

Project No.:	11-P-50242/2-02
Grantee:	New Jersey Department of Human Services Trenton, N.J.
Project Officer:	Patricia Talley Division of Long-Term Care Experimentation

Project No.:	11-P-50270/6-02
Grantee:	New Mexico Human Services Department Santa Fe, N. Mex.
Project Officer:	Dennis M. Nugent Division of Long-Term Care Experimentation

Project No.:	11-P-50256/2-02
Grantee:	New York State Department of Social Services Albany, N.Y.
Project Officer:	Patricia Talley Division of Long-Term Care Experimentation

Project No.:	11-P-50208/6-02
Grantee:	Texas Department of Human Resources Austin, Tex.
Project Officer:	Dennis M. Nugent Division of Long-Term Care Experimentation

Project No.:	11-P-50231/1-02
Grantee:	Department of Social Welfare Montpelier, Vt.
Project Officer:	Patricia Talley Division of Long-Term Care Experimentation

Project No.: 11-P-50238/3-02
Grantee: Virginia Department of Health
Richmond, Va.
Project Officer: Teresa Schoen
Division of Long-Term Care Experimentation

Project No.: 11-P-50229/0-02
Grantee: Department of Social and Health Services
Division of Medical Assistance, LK-11
Olympia, Wash.
Project Officer: Teresa Schoen
Division of Long-Term Care Experimentation

Project No.: 11-P-50264/5-02
Grantee: Department of Health and Social Services
Madison, Wis.
Project Officer: Dennis M. Nugent
Division of Long-Term Care Experimentation

Medicare/Medicaid Hospice Demonstration

Period: October 1980 - October 1983

Description: This demonstration was designed to gather data on the cost, utilization, and quality of hospice care with major emphasis on the provision of home care services (for example, continuous nursing care and prescription drugs). There are 26 sites, and each site provides care to terminally ill Medicare beneficiaries and Medicaid recipients having a life expectancy of 6 months or less. An interdisciplinary team approach is utilized to maintain the patient at home in a comfortable, alert, and pain-free state.

Status: Because Public Law 97-248 mandated a Medicare hospice benefit and the extension of the demonstration, each site continues to enroll Medicare beneficiaries. Medicare utilization statistics for the second year reflected an increase of 43 percent over the first year and Medicaid showed a 4-percent increase. The quality of data being collected not only indicates an understanding and application of the service definitions, but an improvement in the use of project reports and forms and increased perception of the project's objectives.

Project No.: 95-P-50-109/9-02
Grantee: Santa Barbara Visiting Nurse Association
Santa Barbara, Calif.
Project Officer: Teresa Schoen
Division of Long-Term Care Experimentation

Project No.:	95-P-50022/9-02
Grantee:	San Diego Hospice Corporation San Diego, Calif.
Project Officer:	Teresa Schoen Division of Long-Term Care Experimentation

Project No.:	95-P-50194/9-02
Grantee:	Hospice of Marin San Rafael, Calif.
Project Officer:	Teresa Schoen Division of Long-Term Care Experimentation

Project No.:	95-P-50148/9-02
Grantee:	San Pedro Peninsula Hospital San Pedro, Calif.
Project Officer:	Teresa Schoen Division of Long-Term Care Experimentation

Project No.:	95-P-50149/9-02
Grantee:	Hospital Home Health Care Agency of California Torrance, Calif.
Project Officer:	Teresa Schoen Division of Long-Term Care Experimentation

Project No.:	95-P-50020/8-02
Grantee:	Boulder County Hospice, Inc. Boulder, Colo.
Project Officer:	Dennis M. Nugent Division of Long-Term Care Experimentation

Project No.:	95-P-50037/1-02
Grantee:	The Connecticut Hospice, Inc. Branford, Conn.
Project Officer:	Patricia Talley Division of Long-Term Care Experimentation

Project No.:	95-P-50120/4-02
Grantee:	Hospice, Inc. Miami, Fla.
Project Officer:	Patricia Talley Division of Long-Term Care Experimentation

Project No.:	95-P-50079/4-02
Grantee:	Hospice Care, Inc. Seminole, Fla.
Project Officer:	Patricia Talley Division of Long-Term Care Experimentation

Project No.: 95-P-50083/1-02
Grantee: Hospice of the Good Shepherd, Inc.
Waban, Mass.
Project Officer: Patricia Talley
Division of Long-Term Care Experimentation

Project No.: 95-P-50085/1-02
Grantee: University of Massachusetts Medical Center
Palliative Care Service, Inc.
Worcester, Mass.
Project Officer: Patricia Talley
Division of Long-Term Care Experimentation

Project No.: 95-P-50154/5-02
Grantee: Bethesda Lutheran Medical Center
St. Paul, Minn.
Project Officer: Dennis M. Nugent
Division of Long-Term Care Experimentation

Project No.: 95-P-50122/7-02
Grantee: Lutheran Medical Center
St. Louis, Mo.
Project Officer: Dennis M. Nugent
Division of Long-Term Care Experimentation

Project No.: 95-P-50001/2-02
Grantee: Overlook Hospital
Summit, N.J.
Project Officer: Patricia Talley
Division of Long-Term Care Experimentation

Project No.: 95-P-50135/6-02
Grantee: Hospital Home Health Care, Inc.
Albuquerque, N.Mex.
Project Officer: Dennis M. Nugent
Division of Long-Term Care Experimentation

Project No.: 95-P-50006/2-02
Grantee: Cabrini Hospice
New York, N.Y.
Project Officer: Patricia Talley
Division of Long-Term Care Experimentation

Project No.:	95-P-50111/2-02
Grantee:	Genesee Region Home Care Association Rochester, N.Y
Project Officer:	Patricia Talley Division of Long-Term Care Experimentation

Project No.:	95-P-50267/0-02
Grantee:	Providence Medical Center Portland, Oreg.
Project Officer:	Teresa Schoen Division of Long-Term Care Experimentation

Project No.:	95-50068/6-02
Grantee:	The Visiting Nurse Association of Dallas Dallas, Tex.
Project Officer:	Dennis M. Nugent Division of Long-Term Care Experimentation

Project No.:	95-P-50147/6-02
Grantee:	St. Benedict Hospital and Nursing Home San Antonio, Tex.
Project Officer:	Dennis M. Nugent Division of Long-Term Care Experimentation

Project No.:	95-P-50040/1-02
Grantee:	Northern Vermont Respond Burlington, Vt.
Project Officer:	Patricia Talley Division of Long-Term Care Experimentation

Project No.:	95-P-50043/3-02
Grantee:	Hospice of Northern Virginia Arlington, Va.
Project Officer:	Teresa Schoen Division of Long-Term Care Experimentation

Project No.:	95-P-50182/3-02
Grantee:	Medical College of Virginia Richmond, Va.
Project Officer:	Teresa Schoen Division of Long-Term Care Experimentation

Project No.: 95-P-50104/0-02
Grantee: Community Home Health Care
Seattle, Wash.
Project Officer: Teresa Schoen
Division of Long-Term Care Experimentation

Project No.: 95-P-50121/5-02
Grantee: Bellin Memorial Hospital
Green Bay, Wis.
Project Officer: Dennis M. Nugent
Division of Long-Term Care Experimentation

Project No.: 95-P-50132/5-02
Grantee: Rogers Memorial Hospital, Inc.
Oconomowoc, Wis.
Project Officer: Dennis M. Nugent
Division of Long-Term Care Experimentation

National Hospice Study

Project No.: 99-P-97793/1-03
Period: September 1980 - September 1983
Funding: $ 2,890,840
Grantee: Brown University
Providence, R.I.
Project Officer: Spike Duzor
Evaluative Studies Staff

Description: This study will evaluate the effects of providing hospice services to terminally ill Medicare and Medicaid patients. It will determine whether hospice care can provide the necessary emotional, psychological, and medical support to the terminally ill which would permit them to remain at home during their final months of illness and eliminate long and costly periods of institutionalization.

Status: Analytical files are being constructed for the final analysis. These files will link individual patient service utilization and cost information with detailed patient health status profiles and interviews. The final report is expected in September 1983.

Deinstitutionalization of the Chronically Mentally Ill

Project Officer: Jean L. Bainter
Division of Long-Term Care Experimentation

Description: This project is a joint effort between the Departments of Housing and Urban Development (HUD) and Health and Human Services under the Demonstration for Deinstitutionalization of the Chronically Mentally Ill. HUD is providing loans for the construction of community-based housing under section 202, and rental assistance under section 8. The Health Care Financing Administration is providing Medicaid waivers to permit reimbursement for a 3-year period for services such as case management, life skills training, supervision, and transportation.

Status: To date, 12 States have submitted section 1115 waiver-only applications and received approval. There are now 39 sites in operation serving approximately 385 residents. Additional sites are in operation in States not seeking waivers. Several levels of evaluation have been carried out resulting in section 202 standards and criteria for small, scattered site housing. The standards include service requirements for this population that must be monitored by the State Mental Health Authority. To date, there are no findings relating to the cost-effectiveness of the demonstration.

A Model Addressing the Residential Needs of the Chronically Mentally Ill

Project No.: 11-P-98117/6-01
Period: July 1982 - July 1985
Grantee: Arkansas Department of Human Services
Little Rock, Ark.

Effective and Efficient Community Support Services for the Chronically Mentally Ill

Project No.: 11-P-98000/3-02
Period: September 1981 - September 1984
Grantee: Office of Health Care Financing
Washington, D.C.

Cost-Effective Community Alternatives to Institutionalization of the Chronically Mentally Ill

Project No.: 11-P-97575/4-02
Period: April 1981 - March 1984
Grantee: Georgia Department of Medical Assistance
Atlanta, Ga.

Cost-Effective Comprehensive Community Residential Treatment of the Chronically Mentally Ill

Project No.: 11-P-98242/1-01
Period: November 1982 - November 1985
Grantee: Maine Department of Human Services
Augusta, Maine

Housing and Urban Development Demonstration Program for the Chronically Mentally Ill

Project No.: 11-P-97563/5-03
Period: May 1980 - April 1983
Grantee: Minnesota Department of Public Welfare
St. Paul, Minn.

Cost Effective Community Alternatives to Deinstitutionalization of the Chronically Mentally Ill

Project No.: 11-P-98100/1-01
Period: November 1982 - November 1985
Grantee: New Hampshire Division of Welfare
Concord, N.H.

Services in HUD Transitional Housing for Chronically Mentally Ill

Project No.: 11-P-97799/2-01
Period: August 1982 - July 1985
Grantee: New Jersey Department of Human Services
Trenton, N.J.

Deinstitutionalization of the Chronically Mentally Disabled, Cost-Effective Community Alternatives

Project No.: 11-P-98118/1-01
Period: June 1982 - June 1985
Grantee: Department of Social and Rehabilitative Services
Cranston, R.I.

Housing and Urban Development Demonstration Program for the Chronically Mentally Ill

Project No.: 11-P-97952/4-02
Period: May 1981 - May 1984
Grantee: Tennessee Department of Public Health
Nashville, Tenn.

Community Alternatives to the Institutionalization of the Chronically Mentally Ill

Project No.: 11-P-98259/1-01
Period: March 1983 - March 1986
Grantee: Connecticut Department of Income Maintenance
Hartford, Conn.

Cost-Effective Community Residential Treatment for the Mentally Ill

Project No.: 11-P-97787/1-02
Period: August 1981 - July 1984
Grantee: Vermont Agency of Human Services
Waterbury, Vt.

Highline Independent Apartment Living Project

Project No.: 11-P-98200/0-01
Period: April 1982 - April 1985
Grantee: Washington Division of Medical Assistance
Olympia, Wash.

On Lok Community Care Organization for Dependent Adults

Project No.: 95-P-97239/9-04
Period: February 1979 - July 1983
Grantee: On Lok Senior Health Services
San Francisco, Calif.
Project Officer: Jean L. Bainter
Division of Long-Term Care Experimentation

Description: This is a community-based demonstration providing long-term health and health-related services in a health maintenance organization mode. Services are provided to those functionally disabled elderly in the Chinatown-North Beach area of San Francisco that meet the State's eligibility criteria for 24-hour institutional care and who are entitled to Medicare. Medicare waivers were granted to provide reimbursement for a comprehensive package of services and to build a data base for the development of a capitation system of reimbursement.

Status: The On Lok demonstration, which was scheduled for completion on February 28, 1983, has been extended to July 31, 1983, pending the enactment of legislation that is expected to provide permanent reimbursment for community-based long-term care projects. This demonstration is being evaluated by the Health Care Financing Administration in its cross-cutting long-term care study. On Lok's final report is in preparation and includes findings from a comparison study and analyses of cost and services data on the total population.

Study of the Virginia Pre-Admission Screening Program

Project No.: 18-P-98080/3-01
Period: August 1981 - March 1983
Funding: $ 99,880
Grantee: Virginia Commonwealth University
Richmond, Va.
Project Officer: Marni Hall
Division of Economic Analysis

Description: This is a followup study of Virginia's pre-admission screening program for nursing home placement. Research will compare the family supports available and costs of care for two groups of nursing home residents and two groups of community residents using long-term care services.

Status: Preliminary findings indicate that during the 18-month period of the study:

- No detrimental effects, such as an increase in mortality or decline in functional status, were found to occur that could not be explained by initial differences among the groups.

- The screened denial group continues to cost the Medicaid program less than the approval group despite increasing rates of institutionalization. Moreover, they appear to experience no deleterious effects that would indicate needed services were denied.

The final report is expected in June 1983.

Social Health Maintenance Organization Project for Long-Term Care

Project No.: 18-P-97604/1-03
Period: March 1980 - May 1983
Funding: $ 812,756
Grantee: Brandeis University
University Health Policy Consortium
Waltham, Mass.
Project Officers: Tom Kickham and Sidney Trieger
Division of Long-Term Care Experimentation

Description: The purpose of this project is to develop and implement the concept of a social health maintenance organization (S/HMO) for long-term care. An S/HMO integrates health and social services under the direct financial management of the provider of services. All services would be provided by or through the S/HMO at a fixed annual prepaid capitation sum.

Status: Four S/HMO demonstration sites have been selected by the University Health Policy Consortium (UHPC). These sites include two HMO types that will be adding long-term care services to their service packages, and two long-term care providers that will be adding acute care services to their service packages. UHPC has been successful in assisting the sites in obtaining private foundation funding to finance the development period. UHPC is currently working with the sites on developing a common service package, financing plans, and risk-sharing arrangements.

Multipurpose Senior Services Project

Project No.: 11-P-97553/9-04
Period: October 1979 - September 1983
Grantee: State of California Health and Welfare Agency
Sacramento, Calif.
Project Officer: Michael J. Baier
Division of Long-Term Care Experimentation

Description: The purpose of this project is to reduce client hospital and skilled nursing facility days, to reduce total expenditures by social and health services for clients, and to improve clients' functional abilities. Service delivery is administered through eight separate demonstration sites located throughout the State. Each site has an average of 60 organizations with which they contract for the provision of direct services to clients. A wide range of waivered health and social services are provided under the project.

Status: The project is in its fourth and final year. Full caseload (1,900 clients) was reached in the second year of the project. The comparison group (2,500 clients) was recruited without major problem and continues to be interviewed and assessed. Also, a computerized management information system has been developed, and extensive evaluation efforts have been performed. During this fourth year, the focus of the project is shifting from maintenance to wind-down. A special task force of Multipurpose Senior Services Project State and site staff has been formed to identify issues relating to project closure.

Demonstration of Community-Wide Alternative Long-Term Care Model

Project No.:	11-P-90130/2-08
Period:	July 1976 - July 1983
Funding:	$ 960,938
Grantee:	New York State Department of Social Services Albany, N.Y.
Project Officer:	William Saunders Division of Long-Term Care Experimentation

Description: The New York State Department of Social Services is demonstrating alternative approaches to delivering and financing long-term care to the adult disabled and elderly Medicaid population of Monroe County, New York. The project has developed the Assessment for Community Care Services (ACCESS) model as a centralized unit responsible for all aspects of long-term care for Monroe County residents 18 years of age or over who are eligible for Medicaid and have long-term health care needs. ACCESS staff provides each client with comprehensive needs-assessment and case-management services.

Status: The project received waivers to permit provision of certain community long-term care services not normally provided under Medicaid in New York. Since the project became operational in 1977, more than 18,000 people with potential long-term care needs have received assessments under this program.

Continued Demonstration of a Long-Term Care Center Through Inclusion and Expansion of Title XVIII

Project No.: 95-P-97254/2-03
Period: August 1980 - July 1984
Funding: $ 1,802,768
Grantee: Monroe County Long-Term Care Program, Inc.
Rochester, N.Y.
Project Officer: William Saunders
Division of Long-Term Care Experimentation

Description: The purpose of this demonstration is to expand the alternative long-term care delivery model Assessment for Community Care Services (ACCESS) developed for the Medicaid population in Monroe County, New York, to include the county's Medicare population. The addition of this Medicare project is for the purpose of working toward an integration of Medicare and Medicaid long-term care services.

Status: The development phase of this demonstration was completed, and the project began operations in October 1982. The Health Care Financing Administration has contracted with New York Blue Cross to serve as Medicare fiscal intermediary for the demonstration. Thus far, more than 500 Medicare beneficiaries with potential long-term care needs have received assessments from the project.

Home Services for Functionally Disabled Adults

Project No.: 18-P-97462/2-03
Period: June 1980 - June 1983
Funding: $ 488,075
Grantee: Community Service Society
New York, N.Y.
Project Officer: Marni Hall
Division of Economic Analysis

Description: Functionally disabled, low-income adults will be followed for 12 months after acute hospitalization to determine the impact of ongoing home service programs. Access to services, quality of services delivered, participation of informal supports, quality of circumstances, durability of independent living arrangements, and public costs will be examined.

Status: The data collection for the baseline period has been completed. Plans for a followup survey are underway. The project is in the process of obtaining patient-specific Medicare and Medicaid utilization data.

New York State's Long-Term Home Health Care Program

Project No.: 11-P-97155/2-05
Period: September 1978 - September 1983
Funding: $225,688
Grantee: New York State Department of Social Services
Albany, N.Y.
Project Officer: Leslie Saber
Division of Long-Term Care Experimentation

Description: This program provides an alternative to institutionalization for Medicaid clients who meet the medical criteria for skilled nursing facilities (SNF's) or Intermediate Care Facilities (ICF's). A maximum expenditure for home care has been set at 75 percent of the going rate in a locale for SNF or ICF levels of care for which the client is eligible. The program objectives include promoting cost containment by reducing fragmentation in the provision of home care services through a single entry system that coordinates and provides these services.

Status: By the end of the fourth project year, 17 provider sites were operating and the caseload had reached 983 patients. The Health Care Financing Administration approved the project's fifth and final year through September 29, 1983. The final year allows time to complete reassessments, prepare a final report, transmit data to the evaluator, and expand the program Statewide under the authority of Section 2176 (Home and Community-Based Services Program). In December 1982, the program began Statewide expansion.

Evaluation of New York State's Long-Term Home Health Care Program

Project No.: 500-79-0052
Period: September 1979 - September 1983
Funding: $ 742,694
Contractor: Abt Associates, Inc.
Cambridge, Mass.
Project Officer: Kathy Ellingson
Evaluative Studies Staff

Description: The Long-Term Home Health Care Program (LTHHCP) is designed to offer coordinated comprehensive home health care services through a single health care provider to Medicaid-eligible aged or disabled individuals in need of skilled nursing or health-related facility care. The major evaluation objective is to determine whether or not the LTHHCP provides an alternative to institutional care in terms of cost, service use, and quality of care. The research is designed to identify 700 program participants and 700 matched comparison participants, and follow the individuals for at least 1 year by collecting cost and utilization data and applying a health assessment instrument at three points in time. The data being collected are Medicare, Medicaid, Title XX, food stamps, energy assistance, public assistance, and supplemental security income. The final analysis will compare total public expenditures for the program participants to those of the comparison population, with measures of health status outcome for both groups.

Status: A case study qualitative analysis was completed after 1 year of operation. The case study report was completed in March 1983, and will be combined with the quantitative analysis at the end of the study. The resulting final report is expected in September 1983.

South Carolina Community Long-Term Care Project

Project No.: 99-P-97493/4-04
Period: September 1979 - September 1984
Grantee: Department of Social Services
Columbia, S.C.
Project Officer: Leslie Saber
Division of Long-Term Care Experimentation

Description: Through Medicaid and Medicare waivers, the State is conducting a demonstration in three counties to test community-based client assessment, coordination of services, and provision of alternative services. It is anticipated that these waivers will increase the use of home care services, thereby reducing reliance on hospitals and lowering the incidence of conversion from Medicare to Medicaid in nursing homes. The major project objective is to gather information to determine client impact, cost effectiveness, and strategies for implementation in the State's long-term care system.

Status: The project currently has 616 experimental clients and 501 control group clients. In December 1982, the Health Care Financing Administration approved the State's request for a 2-year continuation through September 1984. The State expects to begin implementation of the Medicare waivers in Spring 1983. The project has completed two reports--one on project activities in fiscal year 1980-81, and another on nursing home utilization in the project area. A final evaluation report is expected in Fall 1984.

Modifications of the Texas System of Care for the Elderly: Alternatives to the Institutionalized Aged

Project No.: 11-P-97473/6-04
Period: January 1980 - December 1985
Grantee: Department of Human Resources
Austin, Tex.
Project Officer: Michael J. Baier
Division of Long-Term Care Experimentation

Description: The purpose of this project is to reduce the growth of nursing homes in Texas and, at the same time, expand access to community care services for needy Medicaid individuals. It is being accomplished by directly changing the operating policies of the State's Title XIX and XX programs; in particular, by eliminating the State's lowest level of institutional care--intermediate care facility (ICF) II. Existing organizations responsible for the State's Title XIX and XX programs are responsible for project implementation.

Status: The project is in its fourth year and progress thus far has been good. Of the 15,486 individuals in the "Intermediate Care Facility-II Cohort" group in March 1980, only 7,455, or 48 percent, were still receiving ICF-II services in March 1982. The institutional population decreased 8 percent from March 1980 to March 1982, from 64,876 to 59,744, and monthly expenditures for the institutional population decreased 6 percent, after adjusting for inflation. In fiscal year 1982, a monthly average of 42,491 individuals were receiving community-based services, up 11 percent from fiscal year 1980.

Long-Term Care Demonstration Project of North San Diego County

Project No.: 95-P-97325/9-04
Period: September 1979 - December 1983
Funding: $ 1,063,463
Grantee: Allied Home Health Association, Inc.
San Diego, Calif.
Project Officer: Michael J. Baier
Division of Long-Term Care Experimentation

Description: The purpose of the project is to demonstrate that a Medicare-certified provider of home health services is an appropriate and cost-effective resource for the administration of a long-term care system. The project is comparing client benefits and costs between existing long-term care services and those provided under the project for 500 Medicare beneficiaries. Case-management and client-assessment services are provided by the grantee and waivered services are provided by 19 suppliers of health and social services.

Status: The project is in its fourth and final year. As of September 30, 1982, there were 433 experimental and 206 control patients. During the project's first 2 years, major efforts involved computerizing the Management Information System, developing and field-testing the assessment instrument, negotiating contracts with providers and suppliers, and training project personnel. During the third year, emphasis was placed on service delivery and preliminary evaluation activities. During the fourth year, emphasis will be placed on evaluation activities and winding down the project.

Delivery of Medical and Social Services to the Homebound Elderly: A Demonstration of Intersystem Coordination

Project No.: 18-P-97492/2-03
Period: November 1979 - September 1983
Funding: $ 599,358
Grantee: New York City Department for the Aging
New York City, N.Y.
Project Officer: Michael J. Baier
Division of Long-Term Care Experimentation

Description: The purpose of the project is to document the characteristics of a homebound elderly population in New York City, assess their health care needs, and estimate the costs of delivering needed care. A coordinated health care delivery model has been established to carry out this project on behalf of the 400 experimental Medicare clients. The project organization includes a project advisory committee that is comprised of representatives of relevant city departments, and four neighborhood-based service delivery sites.

Status: The project is in its final year. It reached its full caseload of 400 clients in March 1982. Staff at the four service sites perform case management. Each site also has agreements with various providers to directly render the waivered services and with other agencies to facilitate the coordination of service delivery for clients. During the final year, emphasis is focusing on service delivery, evaluation activities, and efforts relating to the wind-down of the project.

Long-Term Care Demonstration Design and Development

Project No.:	95-P-97231/9-04
Period:	September 1978 - September 1983
Funding:	$ 1,243,368
Grantee:	Mt. Zion Hospital and Medical Center San Francisco, Calif.
Project Officer:	William Saunders Division of Long-Term Care Experimentation

Description: The Mt. Zion Hospital and Medical Center is conducting this Medicare demonstration to implement a hospital-based, long-term care services delivery system in a designated service area in San Francisco, Calif. This model builds upon components of Mt. Zion's existing geriatric services program. A consortium of five service providers under the direction of Mt. Zion cooperate to provide a range of health and social services to the frail elderly in the designated catchment area.

Status: The project has received waivers to permit provision of certain health-related and social services that are not otherwise provided under Medicare. The project became operational in August 1980, and by August 1981, had reached its projected caseload of 200 experimental group members and 100 control group members. The operational phase of the project is scheduled to end on June 30, 1983. The final report is expected in September 1983.

Ancillary Community Care Services: A Health Care System for Chronically Impaired Elderly Persons

Project No.:	11-P-97438/4-04
Period:	October 1979 - September 1983
Grantee:	Department of Health and Rehabilitation Tallahassee, Fla.
Project Officer:	Leslie Saber Division of Long-Term Care Experimentation

Description: The State is conducting a Medicaid demonstration project in five counties. The purpose of the project is to develop and test ancillary community care services for the chronically impaired elderly 60 years of age and over. All eligible clients receive a comprehensive medical-social assessment administered by a physician and social worker. The participating counties are responsible for developing client-care plans based on the assessment, conducting case management, and contracting for services with local providers.

Status: The total number of project participants is 971, with 761 randomly assigned to the experimental group and 210 assigned to the control group. All sites reached full caseload by June 1982. The project is currently in its fourth and final year. Beginning in April 1983, the project sites will work with community agencies to develop an orderly plan for transferring clients from the project to the existing service delivery system. The final project and evaluation reports will be submitted Fall 1983.

Swing Bed

Reducing Acute Care Costs

Project No.: 600-7S-0207
Period: July 1975 - September 1983
Funding: $ 148,535
Contractor: Blue Cross of Western Iowa and South Dakota
Sioux City, Iowa
Project Officer: Tom Kickham
Division of Long-Term Care Experimentation

Description: This project is a swing-bed demonstration that seeks to reduce a hospital's acute care costs while alleviating two problems prevalent in many rural communities: low occupancy rates in the hospital and a shortage of long-term care beds. Essentially, the experiment allows a hospital to use existing staff and facilities to render both acute and long-term care.

Status: Based on the results of swing-bed demonstrations, legislation was introduced in Congress and enacted as part of the Omnibus Reconciliation Act of 1980 (Public Law 96-499) to permit reimbursement of swing-bed care in rural hospitals with less than 50 beds. Regulations implementing this legislation were published on July 20, 1982. Waivers were extended until November 20, 1982, to allow participating hospitals to meet the requirements of the legislation.

Quality

Wisconsin Nursing Home Quality Assurance Project

Project No.: 11-P-97029/5-04
Period: July 1978 - September 1982
Grantee: Wisconsin Department of Health and Social Services
Madison, Wis.
Project Officer: Elizabeth S. Cornelius
Division of Long-Term Care Experimentation

Description: The primary goal of this project was to improve the quality of nursing home care in the demonstration areas without increasing the cost of the State's regulatory system. A screening survey was developed to quicky indentify problems in critical areas. The inspection-of-care process was modified to use sampling techniques rather than performing a review of every patient. This allowed a more in-depth review of selected patients and the identification of prevalent problems on which to focus the survey process.

Status: The demonstration phase of the project was completed in September 1982 and the final report delivered to the Health Care Financing Administration in November 1982. The State conducted seven administrative studies during the course of the demonstration. The overall conclusion reached by the State was that the new methods resulted in no differences in compliance with regulations and no differences in Medicaid reimbursement to facilities. The State also found that fewer surveyor staff hours were required to carry out the modified quality-assurance methods.

Improving New York State's Nursing Home Quality Assurance Program

Project No.: 11-P-97590/2-03
Period: September 1980 - September 1983
Grantee: State of New York Department of Social Services
Albany, N.Y.
Project Officer: Elizabeth S. Cornelius
Division of Long-Term Care Experimentation

Description: This project tests the simplification of federally mandated periodic medical review/independent professional review processes in nursing homes. Surveyors use eleven sentinal health events (SHE), such as accidents, decubitus ulcers, and medication regimen to determine if nursing home patients are receiving quality care. Facilities found to have fewer than the average problems in these areas receive a less than full facility survey. This survey method reduces surveyors' time and allows State personnel to focus on facilities and patients with major problems.

Status: The project has entered its third and final year. The new inspection-of-care processes are fully operational. The State has indicated that it is taking more legal actions than usual as a result of the new processes, but that fewer facilities are being cited for minor problems. During the third year, the project staff will continue to monitor the implementaion of the new methods and integrate them with the new survey process. Plans will be completed to use the Form DMS-1 (Division of Medical Services) for Stage I screening of some SHE's when the system becomes operational. The final report should be submitted to the Health Care Financing Administration by November 30, 1983.

Survey by Exception

Project No.: 11-P-97731/1-02
Period: June 1980 - September 1982
Grantee: Massachusetts Department of Public Welfare
Boston, Mass.
Project Officer: Elizabeth S. Cornelius
Division of Long-Term Care Experimentation

Description: The purpose of this project is to develop and test a method of conducting nursing home surveys so that the intensity of the regulatory effort is matched to the needs of particular facilities. The facilities are grouped according to past performance and the attention is then given to the poorer performers.

Status: The demonstration phase of the project is completed. The State was given permission by the Health Care Financing Administration (HCFA) Regional Office to continue the Survey by Exception methods in most homes. The State has also maintained the control facilities for study by the evaluation contractor. Massachusetts is currently writing the final report. It should be submitted to HCFA for review in Spring 1983.

Quality Assurance Sampling: A Statistical Quality-Control Approach to Inspection of Care

Project No.: 11-P-98260/1-01
Period: March 1983 - February 1986
Grantee: Massachusetts Department of Public Welfare
Boston, Mass.
Project Officer: Elizabeth S. Cornelius
Division of Long-Term Care Experimentation

Description: The main objective of the project is to verify that patients in nursing homes are receiving appropriate care at the appropriate level, without reviewing every patient. Current law requires a review of all patients in a facility to verify the appropriateness of care and placement. This project will use statistical quality control techniques to achieve these goals so that surveyor time can be reallocated to other quality-assurance activities.

Status: The notice of grant award was issued and the project began March 1, 1983.

Evaluation of Three-State Demonstration in Nursing Home Quality Assurance

Project No.: 500-82-0024
Period: August 1982 - August 1984
Funding: $ 444,322
Contractor: Mathematica Policy Research
Madison, Wis.
Project Officer: Spike Duzor
Evaluative Studies Staff

Description: This is an evaluation of the three-State demonstration testing new procedures for conducting nursing home facility surveys and patient quality of care determinations. The States participating in this demonstration include Wisconsin, New York, and Massachusetts.

Status: The contractor is validating the nursing home survey process by accompanying State surveyors during the certification process.

Study of Wisconsin's Quality Assurance Project

Project No.: 18-P-97664/5-02
Period: June 1980 - October 1982
Funding: $ 715,647
Grantee: Wisconsin Health Care Review, Inc.
Madison, Wis.
Project Officer: Richard Yaffe
Evaluative Studies Staff

Description: This 2-year research project examines a demonstration of streamlined nursing home quality assurance (survey, certification, and inspections of care) in terms of cost effectiveness, quality of care, adequacy of process of review, impact of delivery of care, level of care determinations, industry attitudes, and consultation versus regulation.

Status: The final report is expected in Spring 1983.

Data Development and Analyses

Interagency Agreement for Long-Term Care Survey of Individuals in Households

Project No.: IAA-82-0159
Period: October 1981 - September 1984
Funding: $ 500,000
Contractor: Assistant Secretary for Planning and Evaluation
Department of Health and Human Services
Washington, D.C.
Project Officer: Allen Dobson
Office of Research

Description: When the limited budget necessitated a cutback in the Department of Health and Human Services' overall long-term care survey efforts, this project was initiated to provide information on functionally-limited elderly individuals living in households. A sample of 35,000 aged persons was drawn from the Health Care Financing Administration's Health Insurance Master File and was screened by telephone or personal visits to identify individuals having functional limitations for a period of 3 months or longer. The 6,400 functionally-limited persons so identified were interviewed to ascertain information on their limitation, on the formal and informal network supporting them, and on their income.

Status: Data collection was completed in October 1982, with data entry accomplished by December 1982. Data processing of three forms is continuing. Complete cross tabulations, including weighting, are expected in Spring 1983. Further processing to input missing values will be done after that.

Long-Term Care Residential Services for Developmentally Disabled People

Project No.: 18-P-98078/5-02
Period: September 1981 - September 1984
Funding: $ 1,166,635
Grantee: University of Minnesota
Minneapolis, Minn.
Project Officer: Marni Hall
Division of Economic Analysis

Description: This project will update the only national information system on long-term care services for the mentally retarded and developmentally disabled (MR/DD). Data will be gathered on characteristics of residents and facilities, including intermediate care facilities for the mentally retarded. Data from this study will be used to track the effects of recent State deinstitutionalization policies. As part of the project, policy analyses of the cost/utilization of Medicaid MR/DD services will be made.

Status: Data from the national survey of residential facilities are being processed. The annual survey of State mental retardation program directors has been fielded. An analysis of State responses to Section 2176, Public Law 97-135, as it impacts on the mentally retarded, is near completion. The following five papers have been accepted for publication in professional journals:

- "New Admissions and Readmissions to a National Sample of Public Residential Facilities," American Journal on Mental Deficiency.
- Maladaptive Behavior of Mentally Retarded People in Residential Facilities," American Journal on Mental Deficiency.
- "Physical and Behavioral Characteristics of Mentally Retarded People," Journal of Health and Social Work.
- "Changes in Age at First Admission to Residential Care for Mentally Retarded People," Mental Retardation.
- "Response to the General Accounting Office Report to Congress, 'Disparities Still Exist in Who Gets Special Education,'" Exceptional Children.

Home Health Aides

Period: January 1982 - June 1986
Project Officer: Dennis M. Nugent
Division of Long-Term Care Experimentation

Description: Recipients of Aid to Families with Dependent Children (AFDC) will be trained and employed as homemakers/home health aides to provide services to elderly or disabled individuals who, without this support, would require institutionalization. The objectives of the demonstration are to reduce welfare dependency and to prevent or delay the institutional placement of the eligible service clients. This study will measure the costs and benefits of the program, including its contribution to the improvement in employment and earnings capacity of the AFDC recipient and the reduction in the need for institutional care of the functionally impaired home care service client.

Status: The implementation phase of the project began January 1, 1983. Seven States are involved in the project. At this time, some of the States are recruiting and training the AFDC recipients selected to participate in the demonstration. However, the States are at various stages of development.

A Plan for Employing AFDC Recipients as Homemaker/Home Health Aides to Provide Alternatives to Long-Term Care

Project No.: 12-P-98110/6-01
Grantee: Arkansas Department of Human Services
Little Rock, Ark.

Preventacare: An Alternative to Institutionalization

Project No.: 12-P-98111/4-01
Grantee: Kentucky Cabinet for Human Resources
Frankfort, Ky.

AFDC Homemaker/Home Health Aide Demonstration Project

Project No.: 12-P-98113/2-01
Grantee: New Jersey Department of Human Services
Trenton, N.J.

New York State AFDC Homemaker/Home Health Aide Demonstration

Project No.: 12-P-98103/2-01
Grantee: New York State Department of Social Services
Albany, N.Y.

Employment Opportunity for AFDC Recipients in the Homemaker/Home Health Aide Field

Project No.: 12-P-98106/5-01
Grantee: Ohio Department of Public Welfare
Columbus, Ohio

Homemaker/Home Health Aide Project

Project No.: 12-P-98108/4-01
Grantee: South Carolina Department of Social Services
Columbia, S.C.

AFDC Recipients as Providers of Services to Aged and Disabled

Project No.: 12-P-98104/6-01
Grantee: Texas Department of Human Resources
Austin, Tex.

Design Development and Evaluation of the AFDC Homemaker/Home Health Aide Demonstration Project

Project No.: 500-82-0022
Period: June 1982 - June 1986
Funding: $ 454,174
Contractor: Abt Associates, Inc.
Cambridge, Mass.
Project Officer: Kathy Ellingson
Office of Demonstrations and Evaluations

Description: The purpose of this project is to develop a research design to evaluate the Aid to Families with Dependent Children (AFDC)/Homemaker Home Health Aide demonstration and to provide technical assistance to the seven States participating in the demonstration. Following the design, the actual evaluation will occur under separate contracts with the seven participating States. The three major evaluation objectives are to:

- Assess the costs and effectiveness of the training and employment of AFDC recipients as homemakers/home health aides on subsequent, continued, and nonsubsidized employment.
- Assess the costs and outcomes of providing home health aid services to persons at risk of institutionalization who would otherwise not receive these services.
- Assess the net cost effectiveness and provide policy-relevant projections on large-scale implementation.

Status: The contractor has completed three major deliverables: a data resources report; a report on issues in the design implementation; and the final research design.

Other Long-Term Care

Bioactuarial Estimates and Forecasts of Health Care Needs and Disability

Project No.:	18-P-97710/4-03
Period:	June 1980 - August 1984
Funding:	$ 428,650
Grantee:	Duke University Durham, N.C.
Project Officer:	Korbin Liu Division of Economic Analysis

Description: This project employs bioactuarial methods to estimate the need for various types of health services including long-term care. The determinations of levels of need are employed in analyses of the health status of small geographic areas as well as in national projections. The project is also examining how need estimates are being translated into utilization of nursing homes.

Status: Results of this project include estimates and projections of the incidence of specific chronic diseases (for example, cancer) prevalent among the elderly population. In addition, the study has provided new insights on the flow of the elderly population through the nursing home system (for example, admission rates and lengths of stay). Finally, the project is developing profiles of the elderly population in terms of the likelihood of their using alternative modes of long-term care.

Development of Patient Classification of Resource Utilization in Long-Term Care

Project No.: 18-P-97757/1-01
Period: January 1981 - January 1983
Funding: $ 100,000
Grantee: Yale University
New Haven, Conn.
Project Officer: Korbin Liu
Division of Economic Analysis

Description: The purpose of this project was to identify groups of nursing home patients according to their resource consumption. The patient groups were based on combinations of health status characteristics, and resource consumption was measured in terms of nursing staff time.

Status: The study found that for the sample of patients drawn from 36 Connecticut nursing homes, nine resource utilization groups were capable of reducing the variation in nursing staff time by 37 percent. Findings from the study led the investigators to suggest that resource utilization groups can be useful for incorporating patient characteristics in case-mix related reimbursement strategies.

Impact of State Discretionary Policies

Project No.: 18-P-97620/9-03
Period: March 1980 - December 1983
Funding: $ 917,268
Grantee: University of California
San Francisco, Calif.
Project Officer: Marni Hall
Division of Economic Analysis

Description: This is a study of discretionary State policies in Medicare/Medicaid, Title XX, and Supplemental Security Income as they affect long-term care (LTC) services for the aged. Particularly important in the research are the effects that actual or perceived fiscal crisis has on long-term care services. By comparing various States' LTC policies, data about optional approaches to containing LTC costs will be obtained.

Status: Preliminary case studies on each of eight study States have been completed. Personal interviews and a telephone survey of State officials and providers were important sources of information for these case studies. A report that compares policies among the eight study States is in process.

Comparison of the Cost and Quality of Home Health and Nursing Home Care

Project No.: 18-P-97712/8-03
Period: June 1980 - January 1985
Funding: $ 1,225,359
Grantee: University of Colorado
Denver, Colo.
Project Officer: Philip Cotterill
Division of Economic Analysis

Description: This study assesses the cost, quality, and cost-effectiveness of nursing home and home health care provided by free-standing agencies and hospital-based facilities. Detailed data on patient conditions and services are being collected for a national sample of nursing home and home health patients. A subset of patients will be tracked over time to observe outcomes.

Status: Major research design and data collection activities have been completed. The third year activities include initial cost-effectiveness comparisons among the various care modalities.

Pursuit of Institutional Alternatives

Project No.: 18-P-98188/4-01
Period: December 1982 - December 1983
Funding: $ 242,478
Grantee: North Carolina Health Care Facilities Association
Raleigh, N.C.
Project Officer: Marni Hall
Division of Economic Analysis

Description: This study explores the potential participation of North Carolina nursing homes in alternative institutional programs that provide services to the elderly. Alternative programs to be examined for ambulatory and nonambulatory patients are home health care, adult day care, meals on wheels, restorative services, and outpatient services (physical and psychosocial). The legal, organizational, financial, and facility resource requirements will be identified.

Status: This project was initiated in December 1982.

Encouraging Appropriate Care for the Chronically Ill Elderly: A Controlled Experiment to Evaluate the Impacts of Incentive Payments on Nursing Home Admissions, Discharges, Case-Mix, Care, Outcomes, and Costs

Project No.: 11-P-97931/9-02
Period: April 1981 - April 1985
Grantee: California Department of Health Services
Sacramento, Calif.
Project Officer: Teresa Schoen
Division of Long-Term Care Experimentation

Description: The California Skilled Nursing Incentive Payment Project is designed to test a system of monetary incentives as a means of encouraging skilled nursing facilities (SNF's) in San Diego to admit and provide quality care to severely dependent patients. Many patients have more lengthy hospital stays than appropriate because of the amount and cost of care these patients would require in an SNF. Health Care Financing Administration waivers are necessary so that the State may set nursing home rates which exceed the Medicaid reasonable cost requirements by the amount of the incentive payment.

Status: Preliminary results regarding admission incentives are mixed. During the study period, the proportion of Type E patient admissions (patients requiring special nursing, such as comatose care) to treatment group SNF's rose from 6.8 percent to 11 percent, and the proportion of Type E admissions to control group SNF's dropped slightly from 6.1 percent to 5.7 percent. Type D patient admissions (those dependent in all six activities of daily living) remained unchanged for both treatment and control groups.

Competition

A Demonstration of Cost Control and Patient Satisfaction Resulting From the Relaxation of the Maximum Public Enrollment Rule for HMO's

Project No.: 11-P-97986/5-02
Period: April 1981 - March 1984
Grantee: Michigan Department of Social Services
Lansing, Mich.
Project Officer: Eric R. Nevins
Division of Health Systems and Special Studies

Description: The purpose of this demonstration is to test the effects on the cost and quality of care in health maintenance organizations (HMO's) resulting from the relaxation of the regulation requiring that Medicare and Medicaid beneficiaries cannot exceed 75 percent of total HMO enrollment. The project will compare the quality of care provided in HMO's exceeding the limit with HMO's conforming to the regulation through the use of satisfaction surveys.

Status: The project has developed a survey instrument modeled after the one used in the Prepaid Health Research, Evaluation, and Demonstration project (Project No. 96-P-90299/9). The survey questionnaire measures patient satisfaction in relation to seven health care dimensions, in addition to demographics and health care expenses.

Competitive Bidding for Clinical Laboratory Services

Project No.: 500-82-0054
Period: September 1982 - August 1983
Funding: $ 182,318
Contractor: Center for Health Policy Studies
Columbia, Md.
Project Officer: Diane L. Rogler
Division of Hospital Experimentation

Description: The purpose of this 1-year contract is to develop a competitive bidding system for clinical laboratory services. The contract involves a mini-market study to collect and evaluate information about the laboratory industry from three sites, followed by a series of papers addressing the various issues which are important to the design of a bidding system. The end products include a comprehensive description of the competitive bidding system, an implementation strategy, and the documents necessary to solicit bids for Medicare and/or Medicaid.

Status: The draft report of the mini-market study has been submitted. The first issue paper, on freedom of choice, was received in February 1983. The contract ends August 1983.

Evaluation of Health Maintenance Organization (HMO) Capitation Demonstrations

Project No.: 500-81-0017
Period: February 1981 - August 1984
Funding: $ 2,272,672
Contractor: Jurgovan and Blair, Inc.
Rockville, Md.
Project Officer: Alan Friedlob
Evaluative Studies Staff

Description: This evaluation examines the experience of eight health maintenance organizations (HMO's) who have contracted with the Health Care Financing Administration (HCFA) under a pre-paid at-risk basis to provide services to Medicare beenficiaries. These demonstrations are the precursors of current legislation contained in the Tax Equity and Fiscal Responsibility Act of 1982, section 114. The evaluation's objectives are:

- To measure HMO versus fee-for-service differences in utilization patterns for Medicare beneficiaries, standardizing for population differences.
- To assess the accuracy of HCFA's method of estimating what HMO enrollees would have cost under fee-for-service (that is, for the adjusted average per capita cost).
- To measure the extent to which either favorable or adverse selection has occurred, and the cost impact of selection bias in enrollment.
- To assess the cost effectiveness of different marketing methods to the Medicare beneficiary population.
- To assess the fiscal impact of the demonstrations for HCFA, for the HMO, and for beneficiaries.
- To examine the organizational changes in both the administrative and delivery systems conditioned by the addition of seniors to HMO membership.
- To analyze the implications of the demonstrations for national policy.

Status: The actuarial critique was completed in April 1982 and circulated within HCFA. A survey of Medicare beneficiaries who joined the plans and those who chose not to enroll has been completed in Marshfield, Wis., Worcester, Mass., and Minneapolis-St. Paul, Minn. Preliminary findings will be available in Spring 1983. A major report, integrating survey and utilization analyses at Fallon, Marshfield, Kaiser, and the Twin Cities (survey only) demonstration sites will be produced in August 1983.

Medicare Prospective Capitation Demonstration Project

Project No.: 95-P-98147/4-01
Period: April 1982 - March 1986
Grantee: International Medical Centers, Inc.
Miami, Fla.
Project Officer: G. Theodore Saffran
Division of Health Systems and Special Studies

Description: This project will demonstrate and test an alternative to traditional Medicare financing and health care delivery in Miami. The health maintenance organization (HMO) will provide covered Medicare benefits for an amount of reimbursement equal to 95 percent of the adjusted average per capita costs. Several extra benefits are being offered to Medicare beneficiaries at little or no cost, including dental benefit, eyeglasses, hearing aides, prescription drugs, and transportation to the HMO.

Status: Preparation for implementation of the demonstration proceeded from April through July 1982. On August 1, 1982, more than 10,000 Medicare beneficiaries were enrolled in the demonstration. These beneficiaries were already enrolled in a Health Care Financing Administration sponsored section 1876 risk contract. Since that time, International Medical Centers (IMC) has averaged more than 1,000 new members per month. As of January 1, 1983, IMC had 16,631 members. Among the operational problems that have arisen, IMC is having difficulty in negotiating arrangements with area hospitals. IMC has now selected a different claims processing option that will allow the intermediary to pay claims from those hospitals with which IMC cannot arrange an agreement. This project is scheduled for implementation through December 31, 1985, and IMC expects to expand from the present two counties (Dade and Broward) to other counties within the State of Florida.

Enrollment of Medicare Beneficiaries Under a Unique Intra-Health Maintenance Organization Competition Model

Project No.: 95-P-98215/4-01
Period: September 1982 - August 1986
Grantee: CAC Health Plan, Inc.
Miami, Fla.
Project Officer: G. Theodore Saffran
Division of Health Systems and Special Studies

Description: This project will demonstrate and test an alternative to traditional Medicare financing and health care delivery in Miami. The health maintenance organization (HMO) will provide covered Medicare benefits and several extra benefits for an amount of reimbursement equal to 95 percent of the adjusted average per capita costs. A unique feature of the HMO is an enrollee privilege to seek out-of-plan physician services subject to a deductible and copay amount.

Status: The design phase, including protocol, waiver approval, service agreement development and approval, and marketing material approval was completed within 30 days of grant award and the first enrollees in CAC became effective October 1, 1982. As of January 1, 1983, there were 3,117 Medicare enrollees in the plan. The plan offers extensive benefits in addition to Medicare, with no monthly premium. The service agreement is in effect through December 31, 1986.

Medicare Competition Demonstration

Project No.: 500-82-0037
Period: September 1982 - September 1987
Contractor: Av-Med, Inc.
Miami, Fla.
Project Officer: G. Theodore Saffran
Division of Health Systems and Special Studies

Description: This project will test alternatives to traditional Medicare financing and delivery of health services in Miami. Av-Med is a federally qualified, individual practice association model health maintenance organization (HMO), that has a 5-year contract to implement a full-risk prepaid capitation demonstration project in Dade and Broward Counties, Florida. Av-Med is accepting 95 percent of the adjusted average per capita cost and is providing an expanded benefit package with a monthly premium of $ 35. Av-Med has more than 100 independent practice physicians participating in the demonstration. The HMO intends to enroll at least 5,000 Medicare beneficiaries during each year of the demonstration. They also expect to expand to other Florida counties over time.

Status: Av-Med began Medicare demonstration enrollment on November 1, 1982. The entire design phase, that is, protocol development, waivers approval, service delivery contract development and approval, marketing material approval, and implementation of systems changes was completed within 30 days. As of February 1, 1983, more than 600 Medicare beneficiaries are enrolled in Av-Med and marketing efforts are continuing.

Medicare Competition Demonstrations

Project No.: 500-82-0050
Period: September 1982 - September 1987
Funding: $ 363,524
Contractor: Family Health Program, Inc.
Fountain Valley, Calif.
Project Officer: Eric R. Nevins
Division of Health Systems and Special Studies

Description: This is a project designed to develop and test an alternative model for financing and delivering health care services to Medicare beneficiaries living in southern Los Angeles County and Orange County, Calif. Family Health Program (FHP) is a federally qualified health maintenance organization (HMO) which proposed to compete for area beneficiaries by making available an attractive benefit package. FHP presently operates seven major clinical facilities and estimates that these facilities could accommodate 8,000 "senior plan" enrollees. FHP hopes to demonstrate that a

clinical facility, designed specifically for a Medicare population, will improve quality of care and is cost effective. Reimbursement will be based on 95 percent of the adjusted average per capita cost.

Status: The developmental phase of this project is estimated to be 9 months, with enrollment beginning in June 1983. FHP has developed a draft protocol which details operational procedures such a organizational configuration, plan qualifications, benefits, reimbursement mechanisms, marketing, enrollment procedures, and quality assurance. FHP projects to enroll 16,000 Medicare beneficiaries over 2 years once their protocol is approved by the Health Care Financing Administration.

Medicare Competition Demonstration

Project No.: 500-82-0043
Period: September 1982 - September 1987
Contractor: Watts Health Foundation
Los Angeles, Calif.
Project Officer: Eric R. Nevins
Division of Health Systems and Special Studies

Description: This is a project designed to test an alternative model for enhancing competition among providers of care. United Health Plan (UHP) will implement a competitive demonstration through a contract with the Health Care Financing Administration (HCFA) to provide Medicare beneficiaries in the Los Angeles-Orange county area with a comprehensive set of benefits covering physician services, hospitalization, and other medical services. Reimbursement for services will be prospectively determined on a capitation basis. UHP will also provide all administrative, marketing, quality assurance, and utilization control functions required under this contract.

Status: The developmental phase is estimated to be 9 months, with enrollment beginning in June 1983. The draft protocol will be submitted in late February. The protocol defines areas such as organizational configuration, plan qualifications, benefits, reimbursement mechanisms, marketing, enrollment procedures, and quality assurance. UHP projects to enroll 4,000 Medicare beneficiaries the first year once their protocol is approved by HCFA.

Medicare Competition Demonstration

Project No.: 500-82-0049
Period: September 1982 - September 1987
Funding: $ 232,835
Contractor: Blue Cross of California
Van Nuys, Calif.
Project Officer: Nancy Row
Division of Health Systems and Special Studies

Description: This project will test alternatives to traditional Medicare financing and delivery of health services in the Santa Barbara area. Reimbursement will be on a prepaid per capita basis, capitated at 95 percent of the adjusted average per capita cost. Financing will be on a risk basis. Two alternatives will be tested including a preferred provider arrangement.

Status: This project is in its developmental phase. Blue Cross of California has contacted various provider organizations to determine if they will participate. Blue Cross anticipates the project will be implemented in November 1983.

Medicare Competition Demonstration

Project No.: 500-82-0051
Period: September 1982 - September 1987
Funding: $ 980,646
Contractor: Health Choice, Inc.
Portland, Oreg.
Project Officer: Nancy Row
Division of Health Systems and Special Studies

Description: This project will test alternatives to traditional Medicare financing and delivery of health services in the Portland area. Reimbursement will be on a prepaid per capita basis, capitated at 95 percent of the adjusted average per capita cost (AAPCC). Financing will be on a risk basis. Health Choice will establish itself as a broker for Medicare beneficiaries in the county. As broker, it would market to beneficiaries and counsel them as to which alternative health plans (AHP's) are available and what benefits each offer. Health Choice would subcontract to assist organizations in establishing themselves as AHP's.

Status: This project is in its developmental phase. A conference was held in January 1983 with potential provider organizations who would accept risk reimbursement at 95 percent of the AAPCC. A consulting firm will be selected to provide technical assistance to providers. Enrollment is scheduled to begin October 1983.

Medicare Competition Demonstration

Project No.: 500-82-0042
Period: September 1982 - September 1987
Contractor: Maricopa County Department of Health Services
Phoenix, Ariz.
Project Officer: Sidney Trieger
Division of Health Systems and Special Studies

Description: The Maricopa County Department of Health Services (MCDHS) has established an Alternative Health Plan, which is enrolling Medicaid eligibles under the Arizona Alternative Health Care Cost Containment System. MCDHS plans to offer enrollment also to Medicare beneficiaries. They will receive payment from Medicare at 95 percent of the adjusted average per capita cost.

Status: The MCDHS intends to provide a comprehensive range of benefits, including nursing services typically associated with long-term care and not covered by Medicare. MCDHS is establishing the actuarial protocol in April 1983.

Medicare Competition Demonstration

Project No.: 500-82-0046
Period: September 1982 - September 1987
Funding: $ 565,047
Contractor: Harvard Community Health Plan
Boston, Mass.
Project Officer: Nancy Row
Division of Health Systems and Special Studies

Description: This project will test alternatives to traditional Medicare financing and delivery of health services in the Boston area. Reimbursement will be on a prepaid per capita basis, capitated at 95 percent of the adjusted average per capita cost. Financing will be on a risk basis. Harvard Community Health Plan is a successful, federally qualified, staff model health maintenance organization (HMO) operational since 1969. It is one of 14 HMO's in the project area. It plans to enroll 7,200 Medicare beneficiaries by the end of the demonstration. Benefits competitive with Medigap will be offered at lower premiums.

Status: This project is in its developmental phase. Harvard is reviewing the actuarial cost of the Medicare benefit package to determine what additional benefits can be provided. The project is scheduled to begin enrollment October 1983.

Medicare Competition Demonstration

Project No.: 500-82-0045
Period: September 1982 - September 1987
Funding: $ 531,360
Contractor: Blue Cross of Massachusetts
Boston, Mass.
Project Officer: Nancy Row
Division of Health Systems and Special Studies

Description: This project will test alternatives to traditional Medicare financing and delivery of health services in Massachusetts. Reimbursement will be on a prepaid per capita basis, capitated at 95 percent of the adjusted average per capita cost. Financing will be on a risk basis. Under this demonstration, Blue Cross of Massachusetts will establish a Senior Plan Network of four, and possibly five health maintenance organizations (HMO's) in the State. Each HMO will compete with at least one other in its area.

Status: This project is in its developmental phase. Blue Cross of Massachusetts is developing the necessary systems modification to establish the Senior Plan Network. The project is scheduled to begin enrollment in October 1983.

Medicare Competition Demonstration

Project No.: 500-82-0033
Period: September 1982 - September 1987
Contractor: Rhode Island Group Health Association
Providence, R.I.
Project Officer: Nancy Row
Division of Health Systems and Special Studies

Description: This project will test alternatives to traditional Medicare financing and delivery of health services in the Rhode Island area. Reimbursement will be on a prepaid per capita basis, capitated at 95 percent of the adjusted average per capita cost. Financing will be on a risk basis. This project is with an 11-year old, federally qualified health maintenance organization that serves 35,000 members in parts of Rhode Island and Southeast Massachusetts. It currently has a cost contract under which 2,000 Medicare beneficiaries are enrolled.

Status: This project is in its developmental phase. A draft protocol was submitted in March 1983, with enrollment beginning under the risk contract in July 1983.

Medicare Competition Demonstration

Project No.: 500-82-0032
Period: September 1982 - September 1987
Contractor: U.S. Health Care Systems Health Maintenance Organization of Pennsylvania
Willow Grove, Pa.
Project Officer: Shelagh Smith
Division of Health Systems and Special Studies

Description: This project will demonstrate and test an alternative to traditional Medicare financing and delivery of health care services in the Philadelphia metropolitan area. The demonstration is a large, established, federally qualified individual practice association model, health maintenance organization (HMO) that serves 105,000 enrollees in the Philadelphia area, including 1,000 Medicare eligibles under a cost contract. The HMO plans to enroll 7,000 beneficiaries under this project and will be reimbursed at 95 percent of the adjusted average per capita cost after a 12-month developmental phase. Case management, quality assurance, and benefit package enhancement will be emphasized. Seven counties in Pennsylvania and six in New Jersey will be included. An expanded benefit package including ambulatory, diagnostic, laboratory/radiology, preventive, vision care, annual physical evaluation, skilled nursing facilities, and home care is to be offered on a capitation basis as an incentive to attract the Medicare beneficiaries.

Status: Currently, HMO of Pennsylvania has been enrolling Medicare beneficiaries under their cost contract with great success. A protocol describing the demonstration program will be submitted in Fall 1983.

Medicare Competition Demonstration

Project No.: 500-82-0034
Period: September 1982 - September 1987
Contractor: Metropolitan Health Council
Indianapolis, Ind.
Project Officer: Shelagh Smith
Division of Health Systems and Special Studies

Description: This project will test alternatives to traditional Medicare financing and delivery of health services in Indianapolis. The demonstration will be conducted by a federally qualified, staff model health maintenance organization (HMO) with an enrollment of 33,000 members, including 500 Medicare beneficiaries enrolled under a cost contract. Under the study, the HMO will be using one large teaching hospital exclusively for its Medicare enrollees and will implement a risk-sharing arrangement with the hospital under which the hospital will receive a flat percentage of the adjusted average per capita cost (AAPCC). The Metro Health Plan (MHP) wants to test the cost effectiveness of competing for Medicare beneficiaries' enrollment in their plan based on offering an expanded package of benefits on a prospective capitation reimbursement system.

Status: MHP will start enrolling Medicare beneficiaries under this prospective capitation arrangement July 1983 and will be offering their services September 1983. Currently, the Health Care Financing Administration is purchasing from Electronic Data Systems Federal Corporation, the Medicaid fiscal agent, data which will provide us with the percentage of Medicare beneficiaries in institutions to determine the AAPCC. A protocol is expected in April 1983.

Medicare Competition Demonstration

Project No.: 500-82-0047
Period: September 1982 - September 1987
Funding: $ 730,959
Contractor: Health Care Network, Inc.
Oak Park, Mich.
Project Officer: Jerry Riley
Division of Health Systems and Special Studies

Description: This project will test alternatives to traditional Medicare financing and delivery of health services in Detroit. Health Care Network (HCN), owned by Blue Cross of Michigan, is a group model operating in Detroit, a competitive community. HCN is offering a "Medinet" program for Medicare beneficiaries through a network of 25 primary care physicians (PPG) composed of 8 to 25 physicians in each PPG. HCN will include measures for sharing risk for the network for referral services and hospital costs. Enrollees are required to use HCN-approved hospitals.

Status: This project is in its developmental phase. Health Care Network anticipates submitting its draft protocol in April 1983, with the implementation date scheduled for Summer 1983.

Medicare Competition Demonstration

Project No.: 500-82-0038
Period: September 1982 - September 1987
Contractor: Blue Cross and Blue Shield of Michigan
Detroit, Mich.
Project Officer: Jerry Riley
Division of Health Systems and Special Studies

Description: This project will test alternatives to traditional Medicare financing and delivery of health services in Detroit. A Medicare fiscal intermediary currently implementing a capitation demonstration in collaboration with Health Central in Lansing will direct this study based in Detroit, Mich. The intermediary will accept 95 percent of the adjusted average per capita cost from the Health Care Financing Administration for Medicare beneficiaries enrolled in the Detroit area. It will then contract with preferred provider organizations, starting with Detroit Medical Center, to serve beneficiaries at favorable rates.

Status: This project is in its developmental phase. The contractor is currently negotiating with the Detroit Medical Center about the terms of the demonstration, and is seeking other potential preferred providers in the Detroit area. The project is scheduled to become operational in early 1984.

Medicare Competition Demonstration

Project No.: 500-82-0039
Period: September 1982 - September 1987
Contractor: Group Health Plan of Southeast Michigan
Troy, Mich.
Project Officer: Jerry Riley
Division of Health Systems and Special Studies

Description: This project will test alternatives to traditional Medicare financing and delivery of health services in Detroit. The demonstration will involve a federally qualified, staff model health maintenance organization (HMO) that has been in operation since 1977. It serves 24,000 enrollees in the Detroit area, of which 2,000 are enrolled under a Medicaid risk contract. The HMO plans to enroll 1,000 Medicare beneficiaries a year under the demonstration to a total of 3,500.

Status: This project is in its developmental phase. The plan anticipates submitting a draft protocol by April 1, 1983, with a scheduled implementaion date of September 1, 1983.

Medicare Competition Demonstration

Project No.: 500-82-0040
Period: September 1982 - September 1987
Contractor: Health Central, Inc.
Minneapolis, Minn.
Project Officer: Jerry Riley
Division of Health Systems and Special Studies

Description: This project involves the formation and testing of a new entity, a joint venture between St. Paul-Ramsey Medical Center, Amherst H. Wilder Foundation, and Health Central, Inc. This consortium will provide comprehensive medical and institutional services to an enrolled population, and will provide benefits additional to the standard Medicare package, particularly in long-term care. Extensive use of cost sharing is proposed to control utilization.

Status: This project is in its developmental phase. An executive director has been hired for Service Management Center, which is the new organization being established by St. Paul-Ramsey Medical Center, Wilder Foundation and Health Central. Other staff are being recruited. This project is scheduled to become operational in early 1984.

Medicare Competition Demonstration

Project No.: 500-82-0041
Period: September 1982 - September 1987
Contractor: Affiliated Professionals, Inc.
Excelsior, Minn.
Project Officer: Jerry Riley
Division of Health Systems and Special Studies

Description: This project will test alternatives to traditional Medicare financing and delivery of health services in three cities.

Affiliated Professionals (APRO) is a health maintenance organization (HMO) management firm headed by Dr. Paul Elwood. APRO proposes to create a new corporation, Affiliated Professionals-Medicare (MAPRO), a Medicare-only HMO with enrollment at three sites--Detroit, Oakland, and San Diego--with large teaching hospital participation. MAPRO will receive payments from the Health Care Financing Administration and disburse funds to the sites. A health status adjustment to the adjusted average per capita cost will be tested and utilization studied.

Status: This project is in its developmental phase. MAPRO is seeking investors and developing its management capability. It anticipates the demonstration project will be operational in early 1984.

Medicare Competition Demonstration

Project No.: 500-82-0044
Period: September 1982 - September 1987
Contractor: Capital Area Community Health Plan
Latham, N.Y.
Project Officer: Nancy Row
Division of Health Systems and Special Studies

Description: This project will test alternatives to traditional Medicare financing and delivery of health services in the Albany Area. Reimbursement will be on a prepaid per capita basis, capitated at 95 percent of the adjusted average per capita cost. Financing will be on a risk basis. Capital Area Community Health Plan is a federally qualified, staff model health maintenance organization (HMO) operating in a tri-county service area of Albany, Schenectady, and Troy, New York. The HMO has had a Medicare cost contract since 1978.

Status: This project is in its developmental phase. Capital Area is scheduled to submit their draft protocol in Spring 1983, and anticipates initiating enrollment in July 1983.

Medicare Competition Demonstration

Project No.: 500-82-0030
Period: September 1982 - September 1987
Contractor: American Association of Foundations for Medical Care
Bethesda, Md.
Project Officer: Jerry Riley
Division of Health Systems and Special Studies

Description: The purpose of this Medicare competition demonstration is to develop and test alternative models of financing and/or delivering health care for Medicare beneficiaries that enhance competition. The American Association of Foundations for Medical Care, a trade association of individual practice association-model health maintenance organizations (HMO's), will conduct a demonstration involving seven of its HMO's and will test a unique component that involves the establishment of a pooled risk reserve to cover any losses of the HMO's.

Status: This project is in its developmental phase. Part of the draft protocol is being reviewed by the Health Care Financing Administration, and the remainder of the draft protocol is expected in Spring 1983. The project will become operational at the seven participating sites in Summer 1983.

Medicare Competition Demonstration

Project No.: 500-82-0035
Period: September 1982 - September 1987
Contractor: Health Plans Corporation
Nashville, Tenn.
Project Officer: G. Theodore Saffran
Division of Health Systems and Special Studies

Description: This project will demonstrate and test alternative health plans in several cities. Health Plans Corporation is a national health maintenance organization (HMO) management firm that owns or manages 13 HMO's. The demonstration will be conducted at four client sites. All sites are located in competitive areas. The participating plans are:

- HealthCare of Broward (South Florida).
- Health Service Plan of Pennsylvania (Philadelphia).
- Group Health Plan of Northeast Ohio (Cleveland).
- Rockridge Health Plan (Oakland).

Each plan will contract with the Health Care Financing Administration directly. The reimbursement will be 95 percent of the adjusted average per capita cost for the service areas involved.

Status: One of the plans, HealthCare of Broward, became operational on February 1, 1983. The design phase, including protocol, waiver approval, service agreement signature, marketing, and systems changes, was completed for an effective date of February 1, 1983. More than 1,000 Medicare beneficiaries were enrolled as a result of their transfer from a HealthCare of Broward cost contract. The HealthCare of Broward service agreement will be in effect through December 31, 1986.

The other three plans are expected to become operational during Fall 1983. A detailed protocol is expected to be completed during Spring 1983.

Medicare Competition Demonstration

Project No.: 500-82-0031
Period: September 1982 - September 1987
Contractor: Individual Practice Association, Inc.
Rockville, Md.
Project Officer: John F. Meitl
Division of Health Systems and Special Studies

Description: This project will be conducted by a federally qualified, individual practice association (IPA)-model health maintenance organization (HMO) serving upper Washington, D.C., Montgomery County, and portions of Frederick, Prince Georges, and Howard Counties, Maryland, with a current enrollment of 5,000. Its primary care physicians receive an age and sex adjusted capitation fee for enrollees under their care, and have incentives to control referrals. Under this demonstration, the HMO will accept 95 percent of the adjusted average per capita cost (AAPCC) and will provide extra benefits, possibly physicals, eye exams, drugs, and dental care.

Status: MD-IPA has postponed open enrollment until May 1984. The additional months in Phase I will be used to develop new name recognition for the Plan and to conduct a market survey. The Washington, D.C., Medicaid Agency has agreed to produce the institutionalized data for the AAPCC, and the consulting firm, Birch and Davis Associates, Inc., will conduct a survey for the institutionalized data in Maryland.

Medicare Competition Demonstration

Project No.: 500-82-0048
Period: September 1982 - September 1987
Contractor: Group Health Plan of Greater St. Louis
St. Louis, Mo.
Project Officer: John F. Meitl
Division of Health Systems and Special Studies

Description: Group Health Plan of Greater St. Louis is a federally qualified, group practice model health maintenance organization (HMO) with a recent cost contract with the Health Care Financing Administration. The plan is in a designated competitive area with six other HMO's. Reimbursement under this project will be 95 percent of the adjusted average per capita cost (AAPCC). A risk pool for physicians will be established and the plan has reinsurance. Enrollment as of July 1, 1982 was 3,200 members, including 312 Medicare enrollees. The project will include a comparative evaluation of selected marketing approaches and determine if HMO membership has the potential to reduce service utilization.

Status: The Group Health Plan of Greater St. Louis will hold open enrollment in late 1983. The Missouri State Medicaid Agency has submitted institutionalized data for use in calculating the AAPCC.

Development, Implementation, and Management of Medicare Competition Demonstrations

Project No.: 500-83-0005
Period: November 1982 - May 1984
Funding: $ 45,000
Contractor: Birch and Davis Associates, Inc.
Silver Spring, Md.
Project Officer: Jerry Riley
Division of Health Systems and Special Studies

Description: This contractor provides technical support for the Medicare competition demonstrations. Institutional surveys will be conducted to establish the adjusted average per capita costs (AAPCC) for the alternative health plans located in Arizona, Oregon, Massachusetts, and Pennsylvania, and other States where the Medicaid agencies are unable to furnish the required information. Essential support will continue to be provided throughout the demonstration by means of task orders.

Status: Survey forms have been mailed to all institutions in most counties where institutional data are needed. Final results of the survey are expected in Summer 1983. It is anticipated that Birch and Davis Associates will be asked to provide AAPCC's for several projects in the near future.

Alternative Models for Prepaid Capitation of Health Care Services for Medicare Beneficiaries in the Twin Cities Area

Project No.: 500-78-0081
Period: September 1978 - September 1983
Funding: $ 902,887
Contractor: Interstudy, Inc.
Excelsior, Minn.
Project Officer: G. Theodore Saffran
Division of Health Systems and Special Studies

Description: This demonstration is testing competition among four health maintenance organizations (HMO's) for Medicare enrollees in the seven-county Twin Cities area of Minnesota. Interstudy has applied a broker concept to initially market the four plans and each HMO is being reimbursed at 95 percent of the adjusted average per capita cost, using the ratebook approach. Each HMO is competing for the target population through the use of increased benefits, reduced cost sharing, and public education.

Status: This contract had a design phase (September 1978 - September 1980) in which the operational issues and waivers were detailed. In October 1980, the four participating HMO's each signed an implementation agreement with the Health Care Financing Administration (HCFA) to be effective through December 31, 1983. As of January 1, 1983, enrollment in the demonstration has reached 17,327 as follows: Share Health Plan (13,227), MedCenter (2,354), Nicollet/Eitel (1,088), and HMO Minnesota (658). Approximately 1,900 enrollees in Share were formerly enrolled under a HCFA-sponsored cost contract. In July 1982, the Share Health Plan was granted authority to operate in an eighth county (St. Louis), approximately 200 miles northeast of the Twin Cities area.

Alternative Models for Prepaid Capitation Financing of Health Care Services for Medicare

Project No.: 500-80-0062
Period: September 1978 - June 1983
Funding: $ 311,438
Contractor: Marshfield Medical Foundation
Marshfield, Wis.
Project Officer: Nancy Row
Division of Health Systems and Special Studies

Description: This project tested prepaid health care delivery to Medicare beneficiaries in the Marshfield, Wis., area. The project had a risk contract with the Health Care Financing Administration (HCFA) and was reimbursed on a capitated amount less than the adjusted average per capita cost (AAPCC). The benefits offered under the demonstration included all regular Medicare benefits and extra benefits ordinarily included by Marshfield in its supplementary package. Renal beneficiaries were enrolled under a separate, higher capitation rate.

Status: This project completed its operational phase in September 30, 1982, at which point nearly 9,000 beneficiaries were enrolled in the demonstration project. A final report is being prepared by the contractor. Marshfield experienced major financial losses under this demonstration. During most of the demonstration, HCFA participated in a reinsurance agreement to cover losses resulting from hospital utilization in excess of that covered by the AAPCC.

Alternative Models for Prepaid Capitation of Health Care Services for Medicare Recipients

Project No.:	500-78-0082
Period:	September 1978 - December 1983
Funding:	$ 698,843
Contractor:	Fallon Community Health Plan Worcester, Mass.
Project Officer:	Jerry Riley Division of Health Systems and Special Studies

Description: This prospective risk capitation Medicare health maintenance organization demonstration is testing a reimbursement methodology based on an adjusted community rate, with a cap established at 95 percent of the adjusted average per capita cost in its area. Savings will be returned to beneficiaries in the form of increased benefits and reduced cost sharing. A variety of marketing approaches are being tested for effectiveness.

Status: This project just ended its third operational year. It will continue for 1 year more before joining the demonstration project sponsored by Blue Cross of Massachusetts. Fallon's current enrollment stands at approximately 7,000. The Plan offered its enrollees eyeglasses, prescription drugs, and low monthly premium rates. The evaluation of this project is scheduled to be completed in 1984.

Alternate Models for Prepaid Capitation of Health Care Services for Medicare Recipients

Project No.: 500-78-0078
Period: September 1978 - December 1983
Funding: $ 1,044,160
Contractor: Kaiser Foundation
Portland, Oreg.
Project Officer: Jerry Riley
Division of Health Systems and Special Studies

Description: This prospective risk capitation Medicare health maintenance organization demonstration is testing a reimbursement methodology based on 95 percent of the adjusted average per capita cost in the Kaiser Portland/Oregon region. The savings between the capitation rate and the adjusted community rate will be returned to the beneficiaries in the form of increased benefits, reduced cost sharing, or both. A variety of marketing approaches are being tested.

Status: This project has 2-1/2 years of operational experience. Enrollment currently stands at approximately 8,000. The project is scheduled to operate for 1 year more. The completed evaluation of the project is expected in 1984.

Alternate Models for Prepaid Capitation of Health Care Services for Medicare Recipients

Project No.: 500-78-0079
Period: September 1978 - May 1984
Funding: $ 290,861
Contractor: Blue Cross and Blue Shield of Michigan (Health Central)
Detroit, Mich.
Project Officer: G. Theodore Saffran
Division of Health Systems and Special Studies

Description: This prospective risk capitation project is designed to test the effectiveness of a prepaid plan offering additional benefits and reduced cost sharing. The project was designed to test the ability of a newly federally qualified health maintenance organization (HMO) to enroll the Medicare and Medicaid population in Ingham, Eaton, and Clinton counties of Michigan (Lansing area). The HMO involved is Health Central, an affiliate of Blue Cross/Blue Shield of Michigan. An actuarial method is used to set the capitation amount. Thus far, the Health Care Financing Administration's payments have been less than 95 percent of the adjusted average per capita cost amounts on fee-for-service costs.

Status: The design phase was completed by October 1981 and enrollment began in November 1981. By January 1983, there were 571 Medicare enrollees. An attempt to include Medicaid in the demonstration failed when the State and the HMO could not agree upon reimbursement levels for services. Although slow in achieving their goal of 2,000 Medicare enrollees, they are continuing their efforts to provide a comprehensive benefit package for General Motors (GM) retirees in the area. GM constitutes a significant portion of the retirees in that area.

Santa Barbara Health Initiative

Project No.: 11-P-98036/9-02
Period: September 1981 - December 1984
Funding: $ 424,364
Grantee: California Department of Health Services
Sacramento, Calif.
Project Officer: Eric R. Nevins
Division of Health Systems and Special Studies

Description: This research will support Santa Barbara County in the development and testing of a primary care network to serve all categories of the Medicaid population. The county will be reimbursed at 95 percent of projected fee-for-service expenditures and will assume risk for Medicaid services. The primary care physicians will act as case managers, providing primary care and authorizing referrals when necessary. The Santa Barbara Health Authority will advance block payments to hospitals as an incentive to participate and be responsible for proper utilization as controlled by the primary care physician.

Status: The project is to be implemented in two phases--a developmental and an operational phase. Major deliverables submitted during the developmental phase include a provider affiliation plan, a quality assurance and evaluation plan, a risk-sharing plan, and options for reinsurance and reserve allocation. The project is planning to begin enrollment in July 1983.

Monterey County Health Initiative

Project No.: 11-P-98035/9-02
Period: September 1981 - December 1984
Funding: $ 369,490
Grantee: California Department of Health Services
Sacramento, Calif.
Project Officer: Eric R. Nevins
Division of Health Systems and Special Studies

Description: This project is designed to develop and test a capitated primary care network to serve all categories of the Medicaid population in Monterey County. The Health Initiative is organized as a case-management network focusing on the primary physician. The county will be reimbursed at 95 percent of the projected expenditures and will assume risk for Medicaid services. Primary physician accounts will be set up to monitor incoming funds and outgoing expenses. Physicians will be at risk for losses or savings that accumulate in the accounts.

Status: The project is to be implemented in two phases--a developmental and an operational phase. Major deliverables submitted during the developmental phase include a provider participation plan, a quality assurance and evaluation plan, and a plan for risk sharing. The project is planning to begin enrollment in May 1983. The Monterey Health Authority has reviewed and agreed to accept 95 percent fee-for-service capitation payments from the State. An outstanding request from the Health Care Financing Administration is a statement of responsibility for any losses that may be incurred by the Health Authority which is independent of Monterey County.

Florida Alternative Health Plan Project

Project No.:	11-P-98231/4-01
Period:	June 1982 - June 1986
Funding:	$ 729,114
Grantee:	State of Florida Tallahassee, Fla.
Project Officer:	Ronald Deacon Division of Health Systems and Special Studies

Description: This project is designed to demonstrate and test a number of methods for promoting competition among health care providers and insurers. The competitive models include:

- Competitive alternative health plans (competitive procurement process).
- Recipient case management (case management focused on overutilizers).
- Alternative health plan for the frail elderly (risk contracts with organizations to provide health, home, and community-based services on a prepaid basis).
- Medical care vouchers (consumer choice model utilizing non-negotiable voucher).

Status: The grantee intends to develop detailed protocols for each of the four modules which include all operational aspects of the demonstrations. To date, Florida has developed parts of the protocol for the competitive alternative health plans module. A request for procurement to all alternative health plans in Dade and Broward counties is scheduled for release in Summer 1983. Planning and development for the other three modules is occurring; however, protocols are not expected before late Fall 1983. Significant problems have occurred in the Medicare Management Information System (MMIS) process. A new claims process contractor and the lack of specific guidelines on prepaid health plan or health maintenance organization requirements in an MMIS have held up the development of a data protocol.

Medicaid Voucher Demonstration

Project No.: 11-P-98223/5-01
Period: June 1982 - June 1986
Funding: $ 324,374
Grantee: State of Minnesota
St. Paul, Minn.
Project Officer: G. Theodore Saffran
Division of Health Systems and Special Studies

Description: This project is designed to test a Medicaid capitation demonstration with the following major objectives:

- To further the evolution of a competitive health care system by shifting a publicly supported program (Medicaid) to a prepaid basis.
- To control public expenditures for health care by switching from an open-ended provider/consumer-induced demand system to a budgeted, prepaid reimbursement system.
- To create and test various policies and systems for prepaid Medicaid programs.

Status: The design phase is scheduled to be 17 months, followed by a 3-year implementation. The basic accomplishment thus far in the design phase has been the hiring of the Amherst H. Wilder Foundation to be the principal management consulting firm in designing the demonstration. The design is expected to incorporate a means to convert a substantial portion of the Medicaid population in three counties (to be determined) to a prepaid, prospective risk, capitation reimbursement system. If successful, this demonstration should further intensify provider competition in the chosen counties while arresting the cost spiral in the State program. A draft protocol of the operational aspects of the demonstration is expected during Spring 1983 for Health Care Financing Administration review and comment.

Arizona Health Care Cost-Containment System

Project No.: 11-P-98239/9-01
Period: June 1982 - June 1985
Grantee: Department of Health Services
Phoenix, Ariz.
Project Officer: Sidney Trieger
Division of Health Systems and Special Studies

Description: This project is designed to test the effectiveness of establishing under the Social Security Act, Title XIX, a Medicaid program based on competitive principles, including primary care physicians acting as gatekeepers, prepaid capitated contracts, competitive bidding, the use of nominal copayments, limited restrictions on freedom of choice, and capitated payment by the Health Care Financing Administration.

Status: Arizona Health Care Cost-Containment System was implemented October 1, 1982. Completed milestones include: approval of a Section 1115 waiver application and a State plan; selection of MCAUTO systems as the contractor responsible for promotion, procurement of contract providers, provider management, public relations, and program operations; development and approval of a capitation rate.

Missouri Medicaid Prepaid Health Demonstration Project

Project No.: 11-P-98225/7-01
Period: June 1982 - June 1986
Funding: $ 393,917
Grantee: Missouri Department of Social Services
Jefferson City, Mo.
Project Officer: Eric R. Nevins
Division of Health Systems and Special Studies

Description: This project will demonstrate and test a city-wide consumer choice model characterized by the use of various incentives, marketing techniques, and the offering of a range of alternative health plans. The project incorporates components of competitive systems including:

- Consumer choice among alternative health plans.
- Risk sharing based on capitated reimbursements.
- A variety of marketing incentives.
- Participation of a range of organizational types.

All participating plans will offer the mandatory minimum benefit package for the categorically needy under the prepaid arrangement.

Status: Missouri anticipates enrolling 5,000 Medicaid recipients during the first 6 months of the demonstration, with enrollment scheduled to begin in June 1983. The operational protocol will describe the various operational aspects of the demonstration and is due 60 days before the operational period begins. The waivers are contingent on the Health Care Financing Administration's approval of the protocol.

Statewide Medicaid Competition Demonstration

Project No.: 11-P-98222/2-01
Period: June 1982 - June 1986
Funding: $ 792,552
Grantee: New Jersey Department of Human Services
Trenton, N.J.
Project Officer: Eric R. Nevins
Division of Health Systems and Special Studies

Description: This project will demonstrate and test a competitive model in which Medicaid eligibles may select primary care providers as case managers for 6-month intervals that will be responsible for all direct primary care delivery and referrals for ancillary services for noninstitutional recipients. Case managers will be reimbursed on a capitation principle and will be at risk for selected services. The State will contract with broker organizations selected through a bidding process that will be responsible for:

- Marketing to case managers and eligibles.
- Enrolling case managers and eligibles.
- Quality control monitoring.
- Operation of a grievance procedure system for providers and eligibles.

The Professional Standards Review Organization has been selected as the broker for the first phase.

Status: New Jersey anticipates enrolling 15,000 beneficiaries during the first year of the demonstration, with enrollment scheduled to begin in May 1983. A protocol describing the various operational aspects of the demonstration is due 60 days before the operational period begins. The waivers are contingent on the Health Care Financing Administration's approval of the protocol.

Monroe County MediCap Plan

Project No.:	11-P-98230/2-01
Period:	June 1982 - June 1987
Funding:	$ 700,322
Grantee:	New York Department of Social Services Albany, N.Y.
Project Officer:	Nancy Row Division of Health Systems and Special Studies

Description: Monroe County and New York State will participate in a reimbursement demonstration involving a prepaid capitated rate for Medicaid clients involved in the MediCap plan. Participating clients will be offered several delivery alternatives including existing health maintenance organizations, existing clinics or outpatient departments, or a new alternative health plan. A capitated rate, equal to or less than 95 percent of fee-for-service, will be agreed on between the State and County. The County will, in turn, develop rates for categories of eligibles with possible adjustments for types of delivery systems.

Status: This project is in its developmental phase. A draft protocol is scheduled to be submitted by June 1984, with enrollment to begin December 1984. An extensive data base is being developed to construct the Medicaid capitated rate.

Health Maintenance Organization Studies

Physicians' Use of Medical Care Resources in a Prepaid Group Practice Health Maintenance Organization

Project No.: 18-P-97993/9-02
Period: August 1981 - August 1983
Funding: $ 343,814
Grantee: Kaiser Foundation Research Institute
Oakland, Calif.
Project Officer: Mildred Corbin
Office of Research

Description: This research project will measure the intensity of resource use (radiology, laboratory, drugs, outpatient procedures, and hospitalizations) by physicians in a prepaid group practice health maintenance organization, and will determine factors related to differences among physicians in the intensity of resource use. The findings will help to explain differences among physicians in patient-care patterns that affect costs of care and treatment.

Status: Literature review has been completed and summaries partially completed. Most of data preparation has been completed; some preliminary data has been submitted. Adjustments to utilization rates are underway (for morbidity and age differences). A class coverage variable has been created; it identifies patients' type of coverage (high, medium, low). Analysis of the results are getting underway according to schedule.

Health Status Measure for Adjusting Health Maintenance Organization Rates of Medicare Beneficiaries

Project No.: 18-P-98179/5
Period: March 1982 - January 1984
Funding: $ 213,219
Grantee: University of Michigan
School of Public Health
Ann Arbor, Mich.
Project Officer: Marian Gornick
Division of Beneficiary Studies

Description: This study will investigate the use of a health status measure to improve the current method for reimbursing health maintenance organizations for Medicare beneficiaries under the at-risk alternative in section 1876 of the Social Security Act. The project will also explore the ability of simple measures of perceived health status obtained through telephone and mail surveys to predict future utilization and costs for a Medicare population.

Status: Field work has been completed on the survey and a response rate of 80 percent was obtained. Data entry of survey results is now being completed.

Massachusetts Dental Case Management

Project No.: 11-P-97388/1-04
Period: February 1980 - January 1984
Grantee: Massachusetts Department of Public Welfare
Boston, Mass.
Project Officer: Shelagh Smith
Division of Health Systems and Special Studies

Description: The overall goal of this study is to demonstrate that capitated dentistry can result in a cost-effective and improved method of delivering dental care to a Medicaid population. The specific objectives are:

- To demonstrate the effects of case management and capitation on the cost and quality of dental care.
- To evaluate an alternative reimbursement method of providing dental services.

Guaranteed eligibility, capitation, and lock-in to provider (beneficiary restricted to one provider) are three concepts being tested in this demonstration.

Status: The capitated dental coverage for Medicaid beneficiaries has been implemented for 2 years. The project reached 75 percent of its overall enrollment goals. Two thousand Aid to Families with Dependent Children recipients (670 families) have been enrolled in the experimental group. A total of only 30 people have disenrolled since the project began, mainly because they moved out of the service area. Dentists are reimbursed $4.20 per enrolled person per month, a figure that is based upon Schoen's "chair hour" formula. The formula multiplies the estimated amount of dentist and hygienist chair time by the respective costs of that time, all multiplied by estimated overall service utilization. Fourth year tasks are to complete the 2-year demonstration phase and to evaluate the demonstration. The State of Massachusetts is considering whether or not to continue the dental capitation under Medicaid at the conclusion of the demonstration period.

National Medical Care Utilization and Expenditure Survey

Analysis of NMCUES Data

Project No.: 500-81-0047
Period: September 1981 - April 1984
Funding: $ 3,487,763
Contractor: Research Triangle Park Institute
Research Triangle Park, N.C.
Project Officer: Larry S. Corder
Division of Beneficiary Studies

Description: This project involves the analysis of data (tabulations, models, and data file production) and the publication of series reports on the National Medical Care Utilization and Expenditure Survey (NMCUES). This survey was co-sponsored by the Office of Research and Demonstrations, Health Care Financing Administration, and the National Center for Health Statistics, Public Health Service. NMCUES was used to collect detailed sociodemographic, health status, health insurance, and health care payment data that were not available from either the Medicare or Medicaid administrative record systems. Data were obtained from three survey components:

- A randomly selected national household sample (HHS) of the civilian noninstitutionalized population.
- Randomly selected State Medicaid household samples (SMHS) of the civilian noninstitutionalized Medicaid population in four States: California, Michigan, Texas, and New York.
- A Medicare and Medicaid administrative records survey (ARS) linked to HHS and SMHS Medicare and Medicaid respondents.

The data collected will allow for analysis of policy issues that include the New Federalism, Medigap, out-of-pocket costs, and benefit package changes.

Status: The contract is now in its production phase. In addition to answering numerous data requests, nearly half of the 40 planned series reports are now in draft. Twelve reports are expected to be published during fiscal year 1983. These reports will emphasize the relationship of utilization to health insurance coverage, out-of-pocket expenditures, access to health care, and Medicaid use by social and ethnic groups.

Title XIX Data Development

Acquisition and Analysis of State Medicaid Data (Tape-to-Tape)

Project No.: 500-81-0030
Period: June 1981 - December 1983
Funding: $ 1,358,994
Contractor: SysteMetrics, Inc.
Bethesda, Md.
Project Officer: David K. Baugh
Division of Beneficiary Studies

Description: This project is acquiring person-level data on Medicaid enrollment, claims, and providers from State Medicaid Management Information Systems (MMIS). Uniform files are being created to compare State trends. Initial data collection includes five States for 1980 and 1981. These person-level data are a key element to improve the Health Care Financing Administration's ability to conduct program evaluation, strengthen program management, evaluate policy alternatives, and assist States in the area of Medicaid financing.

Status: During 1982, person-level enrollment, claims, and provider files were obtained from State MMIS. System documentation was reviewed and code maps were produced to translate raw data into "uniform" files. Initial data processing and "early returns" tabulations were completed for 1980 Michigan data. Three presentations were made to the 1982 American Public Health Association Annual Meeting, one on long-term care and the other two on use and expenditures under Medicaid.

Medicare Fixed-Price Contracting

Evaluation of Part B Fixed-Price Medicare Contracts

Project No.: 500-81-0041
Period: September 1981 - March 1983
Funding: $ 514,603
Contractor: Abt Associates, Inc.
Cambridge, Mass.
Project Officer: Brad Perry
Divison of Economic Analysis

Description: This project evaluates the Medicare Part B fixed-price carrier experiments in Maine, Illinois, and upstate New York. The evaluation examines the experiments' effects on program costs and quality of carrier performance. Fixed-price arrangements are compared with the previous systems in the three areas. The performance of each experimental contractor is also compared with the performance of two comparable cost-reimbursed contractors.

Status: A final report is expected in Spring 1983. Tentative findings indicate that the fixed-price contractor experiments resulted in reduced Federal costs for carrier

services. The decreased costs were achieved by using different processing sites and better processing systems, and through some economics of scale. With the partial exception of Illinois, no adverse impact of the experiments on beneficiaries or providers has been found.

Program Management

Methodology for Performing Computer-Assisted Simulations of the Effects of Changes in Medical Procedural Terminology Systems

Project No.: 500-78-0013
Period: June 1978 - April 1984
Funding: $ 1,047,631
Contractor: Moshman Associates
Bethesda, Md.
Project Officer: William Sobaski
Division of Reimbursement Studies

Description: This project studies physician response to reimbursement alternatives including analysis of price trends, relative values, and relations between medicine and private health insurance. An objective of the project is to develop and demonstrate a methodology for simulating the effects of changes in medical procedural terminology and coding systems on program outlays, statistics, information systems, and reimbursement levels.

Status: The project to date has:

- Developed California Relative Value Studies, National Association of Blue Shield Plans, and Current Procedural Terminology (CPT) crossovers to the Health Care Financing Administration Common Procedural Coding System (HCPCS).
- Developed Current Procedural Terminology-4, International Classification of Diseases, 9th Revision, Clinical Modification, Volume 3 crossovers.
- Developed a computerized monitoring system.
- Assessed first 2 years of HCPCS usage in South Carolina.

Proposal for the Development of a Medicaid Fraud and Abuse Detection Methodology

Project No.: 11-P-97617/5-02
Period: March 1980 - March 1983
Funding: $ 57,832
Contractor: Illinois Department of Public Aid
Springfield, Ill.
Project Officer: Rose M. Truax
Division of Hospital Experimentation

Description: This 3-year project will develop and field test an empirically-based fraud and abuse detection methodology for the Illinois Medicaid Program to increase the State's review and monitoring capabilities. The basic assumption is the belief that various types of fraud and abuse practiced by Title XIX providers represent conscious decisions regarding trade-offs between:

- Exposure to risk and desired per-unit profit.
- Desired level of effort.
- How those factors relate to a target level of profit associated with practice size.

Status: The grantee examined the data available on providers who were audited between 1973 and 1979. Profiles were developed as a result of the data analysis. Final results will be available in June 1983.

State Legislative Assistance in Health Care Cost Containment

Project No.:	18-P-97062/8-04
Period:	September 1978 - March 1983
Funding:	$ 541,312
Contractor:	National Conference of State Legislatures Denver, Colo.
Project Officer:	Albert W. Jones Division of Hospital Experimentation

Description: This project was initiated as a means of providing assistance and liaison with State legislatures for developing and coordinating State/Federal health care cost-containment efforts. Through conferences, seminars, publications, and direct technical assistance, the National Conference of State Legislatures (NCSL) has:

- Provided State legislatures with timely, adequate, and precise information so that they may make effective decisions regarding health care cost containment.
- Performed a liaison function between the Health Care Financing Administration and State legislatures to facilitate communications and to ensure adequate response to the Nation's health care cost-control problems.

Status: This project terminated March 31, 1983. NCSL filed an application in the January 1983, Health Care Financing Administration grant cycle for approval of a project to continue similar efforts.

State Medicaid Information Center Project

Project No.: 18-P-97923/3-03
Period: January 1981 - January 1985
Funding: $ 719,018
Contractor: National Governors' Association
Washington, D.C.
Project Officer: Darwin Sawyer
Division of Beneficiary Studies

Description: This grant project monitors changes in State Medicaid program policy and disseminates information on these changes through a survey-based report updated every 6 months. The National Governors' Association (NGA) also contracts with research groups outside the Federal Government to produce research reports on special topics of current interest in the area. The project group at NGA works closely with State Medicaid Directors and other program personnel in developing research topics and data collection priorities.

Status: Key products from this project include:

- Medicaid Survey Report: "Recent and Proposed Changes in State Medicaid Programs" from 1982 on, co-published with the Intergovernmental Health Policy Project.
- "Primary Care Network and Medicaid" - A background paper, December 1981
- "Medicaid: Freedom of Choice" - A review of waiver applications submitted under Section 2175 of the Omnibus Budget Reconciliation Act of 1981, August 1982
- "Volume Purchasing of Goods and Services in State Medicaid Programs," October 1982
- "Medicaid Program Changes, State-by-State Profiles," May 1982
- "Controlling Medicaid Costs: Second Surgical Opinion Programs," November 1982
- "Catalog of State Medicaid Program Changes - The State Medicaid Program Information Center," December 1982

Intergovernmental Health Policy Project

Project No.: 18-P-98148/3-01
Period: March 1982 - February 1985
Funding: $ 885,000
Grantee: George Washington University
Washington, D.C. 20052
Project Officer: Darwin Sawyer
Division of Beneficiary Studies

Description: This grant project describes current health law, policy and legislative actions affecting State Medicaid programs. The Intergovernmental Health Policy Project (IHPP) compiles and disseminates information on State health activites, including new developments in the Medicaid cost-containment area. IHPP serves as a clearinghouse on State legislative actions. Through this clearinghouse function, IHPP distributes a monthly newsletter, "State Health Notes," detailing the current status and pending changes in the medical program. IHPP also disseminates special summaries of topical issues in the Medicaid program through the "Legislative Snapshot" report series and periodic background reports.

Status: Key products from this project include:

- Medicaid Survey Report: "Recent and Proposed Changes in State Medicaid Programs" from 1982 on, co-published with the National Governors' Association.
- "State Health Notes," a newsletter published 10 times each year.
- Background reports (for example, "Medigap: Issues and Update, 1982," and "Alternatives to Institutional Care for the Elderly: An Analysis of State Initiatives," September 1981)
- "Legislative Snapshot" (on such topics as nursing homes and Medicaid)

Reporting

Assessment and Redesign of Health Maintenance Organization (HMO) Reporting Requirements Project

Project No.: 18-P-97559/3-02
Period: March 1980 - March 1983
Funding: $ 311,460
Contractor: Group Health Association of America
Washington, D.C.
Project Officer: Nancy Row
Division of Health Systems and Special Studies

Description: The objective of this project was to develop a health maintenance organization (HMO) reporting system that can be used by Federal and State agencies and HMO's to avoid unnecessary duplication and attendant costs.

Status: A final report is being prepared. A document that represents an untested version of a consolidated HMO reporting format to service multiple data users has been prepared. The format builds on integrated core reports that provide summary data on enrollment, utilization, and a variety of financial information.

Policy Centers

Program in Health Care Policy and Financing at Northwestern University

Project No.: 18-P-97265/5-04
Period: September 1978 - March 1983
Funding: $ 2,334,008
Grantee: Northwestern University
Evanston, Ill.
Project Officer: Allen Dobson
Office of Research

Description: The Center for Health Services and Policy Research of Northwestern University assists the Health Care Financing Administration (HCFA) in evaluating and conducting health policy analyses and short-term research projects in priority areas affecting programs that are administered by HCFA. Each year under the 5-year grant, the Center and HCFA develop an agenda of specific topics and projects to conduct. The Center then submits the research and policy papers to HCFA as the studies are completed. They also publish their findings in professional journals.

Status: This policy center is in its fifth and final year of operation. Six studies are being conducted:

- Routine Care of the Foot: Implications of Medicare Exclusion.
- Freestanding Ambulatory Health Centers.
- Cost-Effectiveness of Preventive Health Care for HCFA Beneficiaries.
- Medicare Beneficiary Decisionmaking about Health Plans.
- Lessons from the Experience of State Catastrophic Health Insurance Programs.
- Medicaid Policy.

Final reports on these projects are expected during 1983.

Health Care Financing and Regulation Center

Project No.: 18-P-97038/1-05
Period: May 1978 - May 1983
Funding: $ 3,683,350
Grantee: Brandeis University
Waltham, Mass.
Project Officer: Allen Dobson
Office of Research

Description: The University Health Policy Consortium assists the Health Care Financing Administration (HCFA) in evaluating and conducting health policy analyses and short-term research projects, concentrating in the areas of long-term care, health care quality and effectiveness, and regulation and reimbursement. Each year under the 5-year grant, the Consortium and HCFA develop an agenda of specific topics and projects to conduct. The Consortium then submits the research and policy papers to HCFA as the studies are completed. They also publish their findings in professional journals.

Status: This policy center is in its fifth and final year of operation. There are twelve current projects underway. Of these, five projects were continued from the fourth year of funding:

- Kidney Procurement in the United States.
- Cost Differences Between End-Stage Renal Disease Facilities.
- Home Health Cost Functions.
- Urban Hospital Closing: Qualitative Analysis.
- Mandatory Home Health Studies.

Three projects were related to efforts to improve program efficiency:

- Effect of Medicare Policy on Clinical Policy and Utilization.
- Medicare Cost Control through Claims Analysis.
- Pediatric Appropriateness Evaluation Protocol Instrument.

Three projects were related to issues in competition:

- Adjusted Average Per Capita Costs.
- Vertical Integration of Hospitals and Long-Term Care.
- Competition in Home Health.

One project is related to the issues associated with the New Federalism for Medicaid.

Program Analysis

An Evaluation of Equity Under the Medicare Program

Project No.:	18-P-97874/2-02
Period:	July 1981 - June 1983
Funding:	$ 319,908
Grantee:	Syracuse University Health Studies Program Syracuse, N.Y.
Project Officer:	John Petrie Division of Reimbursement Studies

Description: There are two objectives to this project:

- To reexamine the various concepts of equal access to care and to develop the econometric models suitable for measuring these concepts.

- To confirm previous research findings that Medicare has made substantial gains toward providing equal access to care and that Medicare cost-sharing provisions lead to significantly lower levels of hospital and physician utilization.

It is important that methodological advances be made and tested on the 1977 Current Medicare Survey so that when data from the new Health Care Financing Administration survey of beneficiaries (National Medical Care Utilization and Expenditure Survey) become available, appropriate tools also are available for analysis, and an historical baseline exists with which the new data may be compared.

Status: Four reports have been submitted:

- "Equity and Medicare: Evidence for Vulnerable Elderly Subpopulations."

- "Who Bears the Burden of Medicare Cost-Sharing?"

- "Medicare Cost-Sharing and Private Supplementary Health Insurance: Selected Research Findings."

- "Cost-Sharing, Supplementary Insurance, and Health Service Utilization Among the Medicare Elderly: Revised Estimates."

The findings show that increased cost-sharing in the Medicare program is likely to force low-income beneficiaries to forgo medical care because they are least able to afford supplementary coverage. A report investigating the conditions for the elderly subgroups that prevailed just before Medicare was passed is being written.

Analysis of the Clinical Laboratory Industry

Project No.: 500-78-0048
Period: September 1978 - January 1983
Funding: $ 192,909
Contractor: Rand Corporation
Santa Monica, Calif.
Project Officer: Kenneth Haber
Division of Reimbursement Studies

Description: This study examines how the use of laboratory tests varies with the level of patients' insurance coverage, between a health maintenance organization (HMO) and the fee-for-service system, with physician-laboratory billing arrangements, and with regulation of the clinical laboratory industry. It investigates how Medicare's cost-based reimbursement affects the costs and charges of laboratory tests and to what degree Medicare ceilings on office visit fees and room and board charges result in higher laboratory test charges.

Status: The contractor reports conclude that:

- The percent of the bill covered by a patient's insurance does not influence the number of tests ordered during an outpatient visit.
- Physicians who control billing for tests appear to order more tests per visit than other physicians.
- Laboratory use is lower in an HMO system than in the fee-for-service system.
- Fee ceilings on inputs other than laboratory tests appear to be partially offset by higher test prices.
- Cost-based reimbursement for hospital services appears to increase costs and charges in hospital laboratories.

Medicaid Programmatic Characteristics Research Study

Project No.: 500-81-0040
Period: September 1981 - September 1983
Funding: $ 472,320
Contractor: La Jolla Management Corp.
Rockville, Md.
Project Officer: Donald N. Muse
Division of Medicaid Cost Estimates
Bureau of Data Management and Strategy

Description: This study will design and implement a data system that will, on a selected basis, unify State Medicaid program characteristics, such as eligibility requirements, service limitations, routine statistical report data, and administrative details, in a single source. This data base will be updated periodically for the Health Care Financing Administration (HCFA).

Status: The study has produced, on schedule, a report detailing the first year's characteristics data. A tape containing this data has also been delivered to HCFA. By its conclusion, the study will produce a second year's data tape as well as procedures for HCFA to update the data on an annual basis.

Medicaid Cost Containment and Urban Medical Care

Project No.:	18-P-97728/3-02
Period:	June 1980 - June 1983
Funding:	$ 704,737
Grantee:	The Urban Institute Washington, D.C.
Project Officer:	Allen Dobson Office of Research

Description: The primary objective of this study is to analyze the impact of changes in Medicaid policies on local governments' spending for medical care and hospitals' financial status. The impact on local governments' spending is based on time-series, cross-section data for 22 large cities (in 15 states) over an 11-year period, 1968-1978. Histories of each jurisdiction's Medicaid policies and policy changes are being compiled.

Status: The analysis of hospitals' financial status will be based on a survey of all hospitals with 100 beds or more in the 199 largest cities. The survey will obtain information on charity care, bad debts, and contractual allowances, as well as the distribution of hospitals' revenues by source. These data will be subjected to statistical analyses to identify the effects of interstate variations in Medicaid policies.

Program Evaluation

Design and Evaluation of PSRO Long-Term Care Review

Project No.:	500-80-0049
Period:	June 1980 - October 1981
Funding:	$ 248,181
Contractor:	The Orkand Corporation Silver Spring, Md.
Project Officer:	Sherry A. Terrell Division of Beneficiary Studies

Description: The purpose of this project was to design the evaluation for the long-term care review component of the Professional Standards Review Organization (PSRO) program. A research design was formulated to test hypotheses of PSRO long-term care review effectiveness in assuring appropriate utilization of service by Federal patients. A generic methodology was developed, hypotheses specified, a patient flow model developed, interstate and intrastate PSRO models were developed, and analytical techniques recommended. A descriptive report of the implementation status of PSRO long-term care review through September 1981 was also received. Implementation of the evaluation design was not within the scope of the project.

Status: Completed. Outputs received were:

- Design of An Evaluation of PSRO Long-Term Care Review: Final Report, National Technical Information Service, No. PB 82-131616.
- A Descriptive Analysis of PSRO Long-Term Care Review Programs: Status Report. National Technical Information Service, No. PB 82-131269.

These reports were not published by the Health Care Financing Administration, but are available from the National Technical Information Service .

End-Stage Renal Disease

National Kidney Dialysis and Kidney Transplantation Study

Project No.: 95-P-97887/0-02
Period: January 1981 - January 1984
Funding: $ 776,750
Grantee: Battelle Memorial Institute
Seattle, Wash.
Project Officer: Carl Josephson
Office of Research

Description: The purpose of this study is to analyze the impact of alternative types of therapy on end-stage renal disease (ESRD) patients. Patient outcomes are measured in terms of the patient's quality of life, quality of care, cost of care, and rehabilitation status. Data collection instruments included direct patient interviews, facility-based medical records abstracts, completion of patient medical expense diaries, and the Health Care Financing Administration program data records from entitlement forms, provider certification records, facility survey files, facility cost reports, facility and provider reimbursement records, and other medical information files.

Status: Data based on 850 ESRD patients receiving care under four different types of therapy from 11 renal dialysis centers and facilities were collected during the first 18 months of the study. The next 6 months were spent in the editing and analysis of the basic data and the preparation and publication of 13 supporting documents and 7 major papers. In general, the study found that patients are not randomly assigned to different treatment modalities and that case-mix differences do affect patient outcomes. There were significant differences in the measures of quality of care and quality of life by type of therapy, and these differences persisted after adjusting for differences in patient case mix. Also, significant declines in labor force participation were associated with onset of the renal disease.

The major papers were:

- "Case Mix, Treatment Modalities, and Patient Outcomes: Results of the National Kidney Dialysis and Kidney Transplantation Study."
- "A Comparative Assessment of the Quality of Life of Patients Undergoing Treatment for Chronic Renal Failure."
- "Functional Impairment, Work Disability, and the Availability and Use of Rehabilitation Services by Patients with Chronic Renal Failure."

- "Labor Force Participation Among ESRD Patients."
- "Health Services Utilization and Disability Days: Indicators of the Quality of Patient Care Among ESRD Patients."
- "Premorbid and Post-Treatment Functional Limitations Among Patients with Chronic Renal Failure."
- "Complexities in the Treatment of ESRD: Economic Efficiency and Treatment Modality Prescription."

The final year of the study will be devoted to the analysis and preparation of 16 additional analytical papers.

Encouraging Cost-Effective Treatment of End-Stage Renal Disease

Project No.: 18-P-97585/5-03
Period: March 1980 - March 1983
Funding: $ 203,473
Grantee: Indiana University Foundation
School of Medicine
Indianapolis, Ind.
Project Officer: Paul Eggers
Division of Beneficiary Studies

Description: This project was initiated to develop knowledge on the basic nature and cost of treatment alternatives for end-stage renal disease, and to examine the effects of the changes to the current system by using a computer simulation model to compute cost effectiveness.

Status: Working papers resulting from the project are:

- "Characteristics of the Health Care Financing Administration (HCFA) Home Hemodialysis Patients' Data," July 1982.
- "Descriptive Characteristics of HCFA Renal Transplant Data," May 1982.
- "Outcome Characteristics of HCFA Renal Transplant Data," May 1982.

A final report is expected in June 1983.

Physicians Who Care for End-Stage Renal Disease Patients: A National Study of Their Practices, Patients, and Patient Care

Project No.: 18-P-98174/9
Period: March 1982 - March 1983
Funding: $ 308,978
Grantee: University of Southern California
Los Angeles, Calif.
Project Officer: Peter McMenamin
Division of Reimbursement Studies

Description: This project involved the design and conduct of a national physician-oriented study of the time and effort allocated to various professional activities and patient-care services. The target population included all physicians who render care to patients with end-stage renal disease (ESRD) and who participate in the program under the alternative reimbursement method. Such physicians represent more than 75 percent of the physicians who treat ESRD patients. The study is all inclusive in the sense that the physicians surveyed were asked to report on their entire practice and the full array of their professional activities.

Status: The physician survey began in October 1982 following some delay because of major nephrology professional meetings scheduled in August and September. The response rate was 63.2 percent. A progress report detailing the survey efforts was submitted in January 1983. The grantee has also submitted draft data documentation specifications for the data tapes to be produced by the end of the project.

Evaluation of Reimbursing Home Dialysis Aide Demonstration

Project No.: 500-79-0054
Period: September 1979 - January 1983
Funding: $ 990,037
Contractor: Orkand Corporation
Silver Spring, Md.
Project Officer: Spike Duzor
Evaluative Studies Staff

Description: This study was initiated to evaluate the effectiveness of three demonstrations designed to increase the efficiency of the end-stage renal disease (ESRD) program without reducing the quality of care to ESRD patients. The study was to determine whether patients dialyzing at home assisted by paid aides is less costly than outpatient facility dialysis.

Status: A draft final report is currently being reviewed and will be available in April 1983. Interim findings indicate that home dialysis with an aid is an effective method for reducing ESRD program costs.

Urban Clinics

Urban Health Clinics Demonstration

Project No.: 500-81-0048
Period: September 1981 - December 1985
Funding: $ 891,089
Contractor: SBA/Technassociates, Inc.
Washington, D.C.
Project Officer: Sherrie Fried
Division of Health Systems and Special Studies

Description: The Rural Health Clinics Act of 1977 (Public Law 95-210) mandated that the Department of Health and Human Services conduct demonstrations in urban medically underserved areas to test the relative advantages and disadvantages of cost-based and fee-for-service reimbursement for physician-directed clinics that employ physician extenders (physician assistants or nurse practitioners). The demonstration will involve approximately 70 clinics in California and Tennessee. An appropriate definition of medically underserved areas will also be established.

Status: The 12-month planning and design phase has been completed. The 2-year operational phase will begin in July 1983. A separate contract for the evaluation was awarded to Arthur D. Little, Inc.

Evaluation of the Urban Health Clinics Demonstration

Project No.: 500-82-0025
Period: September 1982 - January 1985
Funding: $ 806,666
Contractor: Arthur D. Little, Inc.
Cambridge, Mass.
Project Officer: Tony Hausner
Evaluative Studies Staff

Description: The purpose of this contract is to evaluate the Urban Health Clinics Demonstration (Project No. 500-81-0048). The evaluation will focus on use, cost, and quality of services.

Status: The data resources report and literature review were completed January 1983. The research design report and final report were delayed because of delays in implementation of the demonstration. The design report is now scheduled for submission in September 1983 and the final report in December 1985.

Technology Costs

Impact of Reimbursement Strategies on the Diffusion of Medical Technology

Project No.: 18-P-97113/3-03
Period: September 1978 - December 1981
Funding: $ 229,404
Grantee: Urban Institute
Washington, D.C.
Project Officer: J. Michael Fitzmaurice
Division of Reimbursement Studies

Description: This project examined the impact of hospital reimbursement characteristics on the diffusion of new technology. A detailed analysis of reimbursement system characteristics in six States was followed by an empirical analysis of adoption behavior with respect to five specific technologies among a sample of hospitals drawn from those States under study. The technologies under examination were electronic fetal monitors, volumetric infusion pumps, upper gastrointestinal fiberoptic endoscopes, automated bacterial susceptibility testing equipment, and computerized energy management systems.

Status: This project was completed in 1982 with the submission of a final report. The Executive Summary is available upon request. Some evidence was found that prospective reimbursement may have reduced the number of capital units but not the speed of diffusion of specific medical technologies. In New York, it appeared that the prospective reimbursement program affected not the decision to innovate, but the number of units to acquire of the cost-raising, clinically oriented technologies--volumetric infusion pumps and upper gastrointestinal fiberoptic endoscopes.

Clinical Social Worker

Medicare Clinical Social Worker Demonstration

Project No.: 500-82-0053
Period: September 1982 - December 1985
Funding: $ 441,345
Contractor: SRI International
Menlo Park, Calif.
Project Officer: Shelagh Smith
Division of Health Systems and Special Studies

Description: The Omnibus Reconciliation Act of 1980 (Public Law 96-499) mandated that the Department of Health and Human Services conduct a demonstration to determine the effects of making the services of clinical social workers more generally available under Medicare. The demonstration will allow direct reimbursement to clinical social workers for their services rather than through a physician or clinic. This contract is for the design and implementation of the direct reimbursement demonstration. There will be a separate contract awarded for the evaluation.

Status: In the initial phase of the project, the contractor has identified the experimental site, Southern California, and tentatively identified the control site. Liaisons with the Health Care Financing Administration Regional Office, State Medicaid Agency, and regional carriers have been established. Initiation of services by clinical social workers is planned for Fall 1983. Major tasks planned for the next 6 months are related to administrative claims processing systems to be implemented by the Medicare carrier in the test site.

Other Coverage

State Policies and Procedures for Determining Medicaid Coverage for Newborns

Project No.: 18-P-97906/5-02
Period: January 1981 - January 1983
Funding: $ 95,339
Grantee: American Academy of Pediatrics
Evanston, Ill.
Project Officer: Judith Sangl
Division of Economic Analysis

Description: This study was done to identify the variety of State Medicaid policies relating to the coverage of newborns and to present realistic options for overcoming the problems created by the current policies. Identifying problematic policies will improve the preventive care available to children eligible for Medicaid.

Status: The first phase of the study has documented the varieties of rules, regulations, and practices that exist among the 50 programs that potentially may deny medical care necessary for newborns or that, in operation, tend to discourage hospitals and physicians from accepting Medicaid patients. The specific rules regarding time and place of application and regulations, such as those requiring billing for services under a newborn's own eligibility number, can act to limit Medicaid coverage of newborns. Within the framework of existing rules, various practices are in operation that may facilitate or prevent the prompt establishment of eligibility. The final report is expected in Spring 1983.

Reexamination of the 44 Freestanding Emergency Centers or Emergicenters

Project No.: 500-82-0027
Period: September 1982 - March 1983
Funding: $ 9,600
Contractor: The Orkand Corp.
Silver Spring, Md.
Project Officer: Benson Dutton
Division of Reimbursement Studies

Description: Performance under this contract consisted of a reexamination of the 44 freestanding emergency centers or emergicenters identified and surveyed in 1979. Efforts were made to contact the management of the original 44 emergicenters. The contractor attempted to identify and list any newly formed emergicenters. A profile of emergicenters was developed based on observable characteristics. Findings from the new survey will be compared and analyzed with those from the 1979 survey.

Status: This project has been completed and the final report is available for distribution.

Study of Medicare Funded Heart Transplants

Project No.: 500-81-0051
Period: September 1981 - September 1983
Funding: $ 1,388,607
Contractor: Battelle Human Affairs Centers
Seattle, Wash.
Project Officer: Brad Perry
Division of Economic Analysis

Description: This project is an evaluation of the scientific, economic, ethical, and social consequences of Medicare coverage for heart transplants. The results will be used to help determine reimbursement policy.

Status: Participating facilities have been selected. Collection of data on heart transplant patients is awaiting the Department of Health and Human Services' Office of Management and Budget clearance of survey instruments. An article that describes the study was published in the November 1982 issue of Heart Transplantation.

Determinants of Current and Future Expenditures on Durable Medical Equipment

Project No.: 18-P-97446/1-03
Period: September 1979 - September 1982
Funding: $ 576,219
Grantee: Williams College
Williamstown, Mass.
Project Officer: G. Theodore Saffran
Division of Health Systems and Special Studies

Description: This 3-year research project was initiated to analyze the structure, conduct, and performance of the durable medical equipment industry. In addition, a model of the demand for durable medical equipment was constructed for the purpose of predicting future expenditures by the Health Care Financing Administration (HCFA) for such items as wheelchairs, hospital beds, etc. The feasibility of rental or purchase of equipment items, in view of economic, medical, or other evidence was also examined.

Status: The draft final report was forwarded to HCFA, and agency review comments were returned to Williams College in December 1982. The final report is expected in April 1983.

Medicare Mental Health Demonstration

Project No.: 500-80-0046
Period: July 1980 - July 1983
Funding: $ 736,000
Contractor: Executive Resource Associates
Arlington, Va.
Project Officer: Melvin Bulkley
Division of Health Systems and Special Studies

Description: This demonstration tests the cost effectiveness and impact of expanded Medicare coverage of outpatient mental health services provided in freestanding community mental health centers and partial hospitalization facilities. Services provided by nonphysician mental health professionals are covered, beneficiary cost-sharing requirements are relaxed, and reimbursement is made on a cost-related basis. The contract provides technical assistance in the implementation and monitoring of the demonstration requirements in the 40 participating facilities.

Status: The demonstration is now nearing the end of its operational phase in April 1983. To date, 7,000 beneficiaries have received services and $9 million has been paid to the facilities for these services. The implementation contractor has made two visits to each facility to verify that they are complying with requirements. Utilization has increased, especially for beneficiaries 65 years of age and over and beneficiaries with no previous mental health treatment. A separate contract for the evaluation was awarded to Macro System, Inc.

Evaluation of the Medicare Mental Health Demonstration

Project No.: 100-80-0148
Period: September 1980 - June 1984
Contractor: Macro System, Inc.
Silver Spring, Md.
Project Officer: Tony Hausner
Evaluative Studies Staff

Description: This project evaluates the utilization and cost implications of a demonstration encompassing 45 sites that waives the physician supervision requirements for Medicare reimbursement to mental health centers. Study areas will focus on assessment of impact of this waiver on mental health services, utilization patterns, overall cost to the Medicare program, and administrative and operational capacity of the participating mental health centers.

Status: The research design was completed in August 1981, and the study is underway. A final report is expected in December 1983, and a supplementary report in June 1984.

Study of the Impact of Rural Health Clinics on the Use of Inpatient Hospital Services

Project No.: 18-P-98061/1-02
Period: August 1981 - August 1983
Funding: $ 118,881
Grantee: Medical Care Development, Inc.
Augusta, Maine
Project Officer: John Petrie
Division of Reimbursement Studies

Description: This study will determine the impact on inpatient hospital use and expenditures of increased access to primary care in areas served by federally funded rural health clinics (RHC's). The researchers expect to learn whether RHC care serves as a substitute for inpatient care, thereby reducing total medical costs of patients in rural communities, or as a complement to inpatient care, thereby increasing these patients' medical costs.

Status: Medical Care Development has selected target and control areas for the study and secured and coded three sets of data: RHC encounter data, hospital discharge data, and Maine population data. No preliminary findings are available yet. A final report is expected by August 1983.

Study to Evaluate the Impact of Rural Health Clinic Services

Project No.: 18-P-97625
Period: July 1980 - June 1983
Funding: $ 416,515
Grantee: University of Washington
Department of Health Services
Seattle, Wash.
Project Officer: Alan Friedlob
Evaluative Studies Staff

Description: The project goal is to assess the contribution of the Rural Health Clinics Act of 1977 (Public Law 95-210) to the development and function of rural health clinics. The study focuses on examining rural health clinics in Idaho and Washington. The study evaluates the use of rural health clinics in these two States by Medicaid beneficiaries and through application of tracer disease methodology, and focuses on the treatment costs for common illnesses at rural health clinics, compared with noncertified clinics and physicians' offices.

Status: A draft report is expected in Spring 1983. A final report will be available by August 1983.

California State Copayment Project

Project No.: 11-P-98206/9-01
Period: March 1982 - March 1985
Grantee: California Department of Health Services
Sacramento, Calif.
Project Officer: John F. Meitl
Division of Health Systems and Special Studies

Description: The purpose of this project is to determine if nominal copayments will reduce inappropriate use of health services while not affecting needed services. Copayments are limited to ambulatory services and are collected by the provider. Early and Periodic Screening, Diagnosis, and Treatment eligibles and Medicare beneficiaries are exempt from all copayments. Copayments are, with some exceptions: $1 for each outpatient, clinic, or physician-type visit; $5 for each visit for nonemergency services received in an emergency room; and $1 for each drug prescription.

Status: The demonstration was implemented on May 10, 1982. Data will be available for evaluation after May 1983.

Medigap Study of Comparative Effectiveness of State Regulations

Project No.: 500-81-0050
Period: September 1980 - September 1983
Funding: $ 1,277,436
Contractor: SRI International
Menlo Park, Calif.
Project Officer: Judith Sangl
Division of Economic Analysis

Description: This study will evaluate the effectiveness of various State regulatory approaches for health insurance sold to the elderly. It contains both a survey of Medicare beneficiaries and of the companies who sell insurance to them. It will be conducted in six States.

Status: The actuarial methodology for evaluating the value of health insurance policies has been developed. The survey instrument for the industry survey has been designed. Analysis of the consumer survey data is expected to be completed in Spring 1983.

Alcoholism Services Demonstration Projects

Period: September 1981 - December 1985
Project Officer: Andrew K. Solarz
Division of Health Systems and Special Studies

Description: The following six projects are a collaborative demonstration between the Office of Research and Demonstrations, Health Care Financing Administration, and the National Institute on Alcohol Abuse and Alcoholism, Public Health Service. These demonstration projects are designed to test the feasibility and cost effectiveness of providing limited coverage for alcoholism treatment services given in freestanding (nonhospital) treatment centers. Each project is uniformly using the following service limits for Medicare and/or Medicaid services:

- Alcohol detoxification - No limit on episodes.
- Inpatient treatment - Up to 30 days per year.
- Outpatient treatment - Up to 45 visits per year.
- Halfway houses - If qualified, can render all of the above services.

Alcoholism Services under Medicaid: Connecticut Demonstration

Project No.: 95-P-97968/1-02
Funding: $ 324,789
Grantee: Connecticut Alcohol and Drug Abuse Commission
Hartford, Conn.

Status: Coverage of services in Connecticut was initiated July 1, 1982. The State has nine providers participating in the demonstration in Medicare only. Provider staff has been trained in billing and cost-reporting procedures. A beneficiary and referral centers demonstration awareness program has been developed within the target area. The continuation application for the second year has been approved.

Alcoholism Services under Medicare and Medicaid: Illinois Demonstration

Project No.: 95-P-97971/5-02 (Medicare)
Funding: $ 159,739
Grantee: Department of Mental Health and Developmental Disabilities
Springfield, Ill.

Project No.: 11-P-97972/5-02 (Medicaid)
Funding: $ 182,000
Grantee: Department of Public Aid
Springfield, Ill.

Status: Coverage of services in Illinois was initiated July 1, 1982. The State has nine providers participating in the demonstration in both Medicare and Medicaid. Provider staff has been trained in billing and cost-reporting procedures. A beneficiary and referral centers demonstration awareness program has been developed within the target area. The continuation application for the second year has been approved. Illinois has developed a prospective rate for alcoholism services that will be used in the project.

Alcoholism Services under Medicare and Medicaid: Michigan Demonstration

Project No.: 95-P-97975/5-02 (Medicare)
Funding: $ 59,053
Grantee: Office of Substance Abuse Services
Department of Public Health
Lansing, Mich.

Project No.: 11-P-97976/5-02 (Medicaid)
Funding: $ 277,346
Grantee: Medical Services Administration
Department of Social Services
Lansing, Mich.

Status: Coverage of services in Michigan was initiated July 1, 1982. The State has 16 providers participating in the demonstration in both Medicare and Medicaid. Provider staff has been trained in billing and cost-reporting procedures. A beneficiary and referral centers demonstration awareness program has been developed within the target area. The continuation application for the second year has been approved.

Alcoholism Services under Medicare and Medicaid: New Jersey Demonstration

Project No.: 99-P-97973/2-02
Funding: $ 416,340
Grantee: Division of Medical Assistance and Health Services
Trenton, N.J.

Status: Coverage of services in New Jersey was initiated August 1982 for Medicare and in October 1982 for Medicaid. The State has 13 providers participating in the demonstration in both Medicare and Medicaid. Provider staff has been trained in billing and cost-reporting procedures. A beneficiary and referral centers demonstration awareness program has been developed within the target area. The continuation application for the second year has been approved.

Alcoholism Services under Medicare and Medicaid: New York Demonstration

Project No.: 99-P-97979/2-02
Funding: $ 403,383
Grantee: Division of Medical Assistance
Department of Social Services
Albany, N.Y.

Status: Coverage of services in New York was initiated July 1, 1982. The State has 10 providers participating in the demonstration in both Medicare and Medicaid. Provider staff has been trained in billing and cost-reporting procedures. A beneficiary and referral centers demonstration awareness program has been developed within the target area. The continuation application for the second year has been approved.

Alcoholism Services under Medicare: Oklahoma Demonstration

Project No.: 95-P-97983/6-02
Period: September 1981 - December 1985
Funding: $ 600,000
Grantee: American Indian Institute
University of Oklahoma
Norman, Okla.

Status: Coverage of services in Oklahoma was initiated July 1, 1982. The State has 13 providers participating in the demonstration in Medicare only. Provider staff has been trained in billing and cost-reporting procedures. A beneficiary and referral centers demonstration awareness program has been developed within the target area. The continuation application for the second year has been approved.

Evaluation of the Alcoholism Services Demonstration

Project No.: 500-81-0049
Period: September 1981 - June 1983
Funding: $ 356,557
Contractor: Lawrence Johnson and Associates, Inc.
Washington, D.C.
Project Officer: Tony Hausner
Evaluative Studies Staff

Description: This is an evaluation of the effectiveness of the demonstration that expands Medicare and/or Medicaid coverage to free-standing alcoholism treatment centers. It will examine the impact of the demonstration on the use and cost of services. The project is supported by funds from the National Institute on Alcohol Abuse and Alcoholism, Public Health Service.

Status: The research design was submitted for review August 1982. The revised research design report is expected in Spring 1983. A contract for subsequent phases of this evaluation will be awarded following completion of the current contract.

Obstetrical Access Pilot Project

Project No.: 11-P-97223/9-03
Period: July 1979 - March 1983
Grantee: Department of Health Services
Sacramento, Calif.
Project Officer: Andrew K. Solarz, Ph.D.
Division of Health Systems and Special Studies

Description: This project will test the hypothesis that the provision of early access to obstetrical services for low-income pregnant women will reduce subsequent morbidity of both infants and mothers. Services include health education, nutrition, and psychosocial assessments in addition to prenatal, delivery, and postpartum services. They comprise prenatal services not otherwise reimbursed under the Medi-Cal program, but are provided in this pilot project.

Status: The project has 10 clinical sites in operation and is gathering appropriate health, treatment, and claims data. More than 6,000 patients have been registered for services to date, and 7,000 registrants are expected by Spring 1983. A separate grant for the evaluation was awarded to the California Department of Health Services.

Evaluation of Obstretrical Access Pilot Project

Project No.: 11-P-97578/9-03
Period: March 1980 - December 1983
Funding: $ 203,370
Grantee: Department of Health Services
Sacramento, Calif.
Project Officer: Tony Hausner
Evaluative Studies Staff

Description: The purpose of this grant is to conduct an evaluation of the Obstetrical Access Pilot Project (Project No. 11-P-97223/9-03).

Status: The research design was completed in December 1981. An interim report was submitted in December 1982 to the State legislature. A key finding is that the project reduced the rate of low-birthweight babies. The final report is expected in December 1983.

Child Health

Health Care Services for Children Under Medicaid

Project No.: 18-P-98011/3
Period: August 1981 - September 1983
Funding: $ 425,605
Grantee: John Hopkins University
School of Medicine
Department of Pediatrics
Baltimore, Md.
Project Officer: Benson Dutton
Division of Reimbursement Studies

Description: The Health Care Financing Administration approved a grant for a comparative study of health care services for children by using billing claims and eligibility data files from the State of Maryland. The grantee seeks information on the cost and effectiveness of services for children eligible for the Medicaid Early Periodic Screening, Diagnosis, and Treatment Program (EPSDT). Data on the costs and utilization of services for children using private practitioners, hospital clinics, emergency rooms, and various combinations of delivery systems serve as the bases for this analysis.

Status: Accomplishments to date include:

- Meetings with State Medicaid agencies.
- Completion of preliminary analysis of Children and Youth Project data, and records of eligibility for input into the data base.
- Acquisition of eligibility tape files.
- Conversion of eligibility tape files and payment files.

Other Prevention

Municipal Health Services Program

Project No.: Cooperative Agreement
Period: August 1979 - December 1984
Participants: Baltimore, Md.
Cincinnati, Ohio
Milwaukee, Wis.
St. Louis, Mo.
San Jose, Calif.
Project Officer: Shelagh Smith
Division of Health Systems and Special Studies

Description: Municipal Health Services Program (MHSP) is a collaborative effort of five major cities in five States, the U.S. Conference of Mayors, the Robert Wood Johnson Foundation (RWJF), and the Health Care Financing Administration (HCFA). It was initiated by RWJF through grants of $3 million awarded in June 1978 to each of the following five cities: Baltimore, Cincinnati, Milwaukee, St. Louis, and San Jose.

HCFA joined in the project by providing Medicare waivers through a cooperative agreement and Medicaid waivers to test the effects of increased utilization of municipal health centers by:

- Eliminating coinsurance and deductibles.
- Expanding the range of covered services.
- Paying the cities the full cost of delivering services at the clinics.

The intent of the waivers is to shift fragmented utilization away from costly hospital emergency rooms and outpatient departments toward lower cost Municipal Health Services Program (MHSP) clinics which would provide beneficiaries with comprehensive, primary and preventive health care.

Status: The first city began billing under the Medicare waiver in August 1979. Four of the five cities (all except Cincinnati) desired to use Medicaid waivers as well, and this brought in participation of the State Governments in 1981. As of January 1982, the five MHSP cities have a total of 19 clinics operating, bringing together both public and private health-related organizations. A wide variety of services are offered, including medical, social, mental, preventive, dental, optometry, podiatry, and rehabilitation. Clinic utilization ranges widely from 700 visits per year to 40,000 visits per year. Average provider productivity ranges from 3,200 to 4,500 annual visits per full-time equivalent provider.

Evaluation of Muncipal Health Services Program

Project No.:	500-78-0097
Period:	September 1978 - March 1984
Funding:	$ 3,105,250
Contractor:	University of Chicago Chicago, Ill.
Project Officer:	Tony Hausner Evaluative Studies Staff

Description: This is an evaluation of the Municipal Health Services Program demonstrations. It is a collaborative effort with the Robert Wood Johnson Foundation. The evaluation covers the quality and efficiency of services delivered in urban clinics in five cities (Baltimore, Cinncinati, Milwaukee, St. Louis, and San Jose).

Status: The contractor has submitted interim reports covering the baseline survey and secondary data resources. The final report, which will include data from the followup survey, is expected in March 1984.

Quality and Effectiveness of Preventive Medical Care

Project No.: 18-P-97777/9
Period: September 1980 - March 1984
Funding: $ 596,804
Grantee: Rand Corporation
Santa Monica, Calif.
Project Officer: Benson Dutton
Division of Reimbursement Studies

Description: This study focuses on the effect of preventive care on various categories of medical expenditure and any losses attributed to sickness. Issues and questions to be addressed include:

- The effects of preventive care on health status, medical care use, and work time available.
- The responsiveness of consumer demand to changes in the price of preventive care.
- The amounts of preventive care used in prepaid systems versus fee-for-service practice settings, both with no out-of-pocket charges.
- Whether or not people choosing the prepayment plan are fundamentally different in their desires to obtain preventive care.

The study will use data from the Rand Health Insurance Study (HIS), a social experiment in which families are assigned to several different health insurance plans. Approximately 8,000 individuals have been enrolled at six sites across the country: Dayton, Ohio; Seattle, Washington; Fitchburg, Massachusetts; Franklin County, Massachusetts; Charleston, South Carolina; and Georgetown County, South Carolina.

Status: The tasks for the 3-year study include the following. During the first year, working knowledge of the relevant HIS data will be developed; computer programs will be constructed; literature review undertaken; and the analytic design will be refined. In the second year, analyses will be performed on the Dayton, Seattle, and Fitchburg/Franklin 3-year sample data; and the analytic design and computer software further developed. The third year will be spent extending the analysis to the 5-year samples, further developing the analytic design, and preparing reports. Expectations are that the study will produce a fairly detailed and complete picture of the causes of preventive care expenditures and the consequences for health outcomes, and acute and chronic medical care expenses.

Evaluation of the Impact of Second Opinions for Elective Surgery

Project: 500-78-0047
Period: September 1978 - September 1983
Funding: $ 2,225,791
Contractor: Abt Associates, Inc.
Cambridge, Mass.
Project Officer: Alan Friedlob
Evaluative Studies Staff

Description: The objective of this evaluation is to determine the effect of formal second opinion programs on surgery rates, surgical costs, and the health of patients who forgo surgery as a result of obtaining a second opinion. The basis of the evaluation is two voluntary Medicare Second Surgical Opinion Programs (SSOP) in New York City and Detroit, the State of Massachusetts' mandatory Medicaid SSOP, and the Health Care Financing Administration's (HCFA) public information second surgical opinion program.

Status: A major report has been produced. Based on this report, the Office of Research and Demonstrations, HCFA, prepared a report to Congress on the desirability of waiving Medicare cost-sharing for voluntarily sought second surgical opinions. This study is summarized in a brief report in the September 1982 issue of the Health Care Financing Review. A survey of 445 Medicare beneficiaries in New York City--both voluntary program users and control group beneficiaries (who were recommended for select procedures but who did not use the program)--has been completed. Five papers analyzing this data are in preparation and expected to be completed by September 1983.

Cooperative Health Education Project

Project No.: 18-P-97191/3-03
Period: February 1980 - January 1983
Funding: $ 261,245
Grantee: Center for Consumer Health Education
Vienna, Va.
Project Officer: Shelagh Smith
Division of Health Systems and Special Studies

Description: The Cooperative Health Education Project is a large, quasi-experimentally designed project that investigates the impact of several levels of educational interventions on utilization of prepaid health care services and on individual health risk behaviors. The interventions emphasize self-care and self-responsibility for health. Printed materials (books and newsletters on health and self-care), a telephone information service, and a conference with a nurse practitioner are the major interventions used. The project is implemented at two health maintenance organizations: Prime Health in Kansas City, Mo., and Rhode Island Group Health Association in Providence, R. I.

Status: The final report is due in Spring 1983, and preliminary results are encouraging. The experimental group receiving the health education intervention showed a 15-percent reduction in utilization of total ambulatory visits.

Medicare End-Stage Renal Disease Experience

Contact: Paul Eggers
Division of Beneficiary Studies

Description: This study examines overall trends in the Medicare end-stage renal disease (ESRD) program. Changes in incidence, prevalence, and patient survival will be explored. In addition, changes in patient characteristics such as age, sex, race, and diagnosis will be documented. Medicare reimbursements for ESRD patients will be analyzed as well, including hospital costs, physician costs, and outpatient dialysis costs. Special analyses will be done on transplant patients.

Status: The following papers and reports have been generated from this study:

- "Life Expectancy and Use of Services by Persons With End-Stage Renal Disease Enrolled in Medicare." Paper presented at the American Public Health Association Annual Meeting, New York, 1979.
- "Analyses of Indicators of Case-Mix Differences Between Freestanding Facility and Hospital-Based Medicare ESRD Patients." Working Paper No. OR-33, Office of Research and Demonstrations, Health Care Financing Administration, May 1982.
- "Trends in Incidence, Prevalence, Survival, and Reimbursement in Medicare ESRD Patients." Working Paper No. OR-40, Office of Research and Demonstrations, Health Care Financing Administration, April 1982.
- "Medicare Program Experience With End-Stage Renal Disease." Paper presented at the New York Academy of Sciences, New York, January 1983.
- "Uses of the End-Stage Renal Disease Medical Information System for Epidemiological Research." Paper presented at the National Nephrology Foundation, New York, January 1983.
- "The Medicare Experience With End-Stage Renal Disease: Trends in Incidence, Prevalence, and Survival." In preparation for the Health Care Financing Review.
- "The Medicare Experience With End-Stage Renal Disease: Trends in Reimbursements." In preparation for the Health Care Financing Review.

Puerto Rican Medicaid Program

Contact: Aileen Pagan-Berlucchi
Division of Beneficiary Studies

Description: This project provides a broad overview of the Puerto Rican health care delivery system, detailing its differences with that of the United States. It describes the organization and operation of the Puerto Rican Medicaid program in terms of basic expenditures and utilization data. In addition, this project serves as a case study of how such a program operates when Federal financing is "capped" over a period of time.

Status: A special report on this project will be published in the Summer 1983 issue of the Health Care Financing Review.

Medicaid/Medicare Data Book

Contact: Darwin Sawyer
Division of Beneficiary Studies

Description: This report provides descriptive statistics on the organization and operation of the Medicare and Medicaid programs. It features cross-program comparisons on recent trends in program recipients, expenditures, and service utilization as well as in-depth discussions of the basic operating principles of each program. Several appendixes are also included that detail relevant studies on selected issues in each program, sources of information contained in the book, and the names and addresses of program officials at the Federal and State levels. This report is intended as a resource tool for public officials, researchers, policy analysts, and health care consumers and providers.

Status: The Medicare and Medicaid Data Book, 1981 was the first edition of this report, and it is available upon request from: Office of Research and Demonstrations, Publications Staff, Rm. 2-E-6, Oak Meadows Building, 6325 Security Boulevard, Baltimore, Md. 21207. The 1982 edition is due to be released in late Summer 1983.

Use of Services by the Dually Entitled

Contact: James Lubitz
Division of Beneficiary Studies

Description: More than 13 percent of the aged population are covered by both Medicare and Medicaid. In view of the proposed and recently enacted changes in both programs, the health care use of the dually entitled is of special interest.

Status: A recently completed study of Medicare use by the dually entitled, scheduled for publication in the Summer 1983 issue of the Health Care Financing Review, found that per capita Medicare reimbursement for the dually entitled was 50 percent higher than for other enrollees. The mortality rate was also 50 percent higher for the dually entitled. The study also found that the relative mortality rate of the

dually entitled, compared with other Medicare enrollees, was highest in the youngest age group. In the group 65-69 years of age, the death rate for the dually entitled was 80 percent higher than for other enrollees; in the group 85 years of age and over, the rate was 30 percent higher. Two further studies are in progress on the dually entitled. The first uses the National Medical Care Utilization and Expenditure Survey to examine utilization and reimbursements made by Medicare, Medicaid, and other sources, and the relation of health status, education, and income to health service use. This study is confined to noninstitutionalized persons. The second study includes institutionalized and noninstitutionalized enrollees and uses person-level data from Medicare and Medicaid in selected States. It will focus on patterns of long-term care and hospital use by the dually entitled.

Use of Medicare Services by Disabled Enrollees Under 65 Years of Age

Contact: James Lubitz
Division of Beneficiary Studies

Description: More research has been devoted to the Medicare aged population than to the population of disabled enrollees under 65 years of age. Yet disabled enrollees comprise about 10 percent of Medicare enrollment, and Medicare expenditures for them have been rising faster than for aged enrollees. To increase available knowledge of the Medicare disabled population, analyses are being carried out on patterns of health services used by the disabled.

Status: Early results indicate that per capita reimbursement for the disabled are equal to that of the aged and that disabled women exceed men in per capita reimbursement. An important part of the analysis involves linking the Social Security Administration's Disability History File to Medicare records. When the link is completed, analyses will examine the relationship of reason for disability and length of time disabled to health care use.

Post-Surgical Mortality Among the Aged for Common Operations

Contact: James Lubitz
Division of Beneficiary Studies

Description: About 2.5 million hospital stays for surgery for Medicare enrollees occur annually. Much of this surgery is to some extent discretionary. Thus, to the extent that some of these surgical procedures could be avoided, some of the associated mortality might be reduced. This study examines mortality up to a year after five common operations--cholecystectomy, prostatectomy, inguinal hernia repair, cataract removal, and hip repair--comprising about one-quarter of operations for Medicare enrollees.

Status: Preliminary results show that the risk of dying markedly increases with age and that patients operated on for prostatectomy and hip repair have higher than average mortality for up to a year following the operation. Preliminary results also show lower post-surgical mortality in the West for all five operations. Further analyses

will examine other operations and will examine the effect of other factors such as race and hospital characteristics on mortality.

Impact of Deductibles and Coinsurance on Medicare Enrollees

Contact: James Lubitz
Division of Beneficiary Studies

Description: More than half of Medicare enrollees purchase private supplemental policies ("Medigap") to protect against the costs of Medicare deductibles and coinsurance. This study examines the distribution of liabilities for Medicare cost-sharing and offers proposals for restructuring Medicare coverage to both reduce the need to purchase Medigap coverage and to better protect against catastrophic cost-sharing liabilities.

Status: A report of this study is scheduled for publication in the Fall 1983 issue of the Health Care Financing Review. In 1978, 20 percent of Medicare enrollees had Medicare cost-sharing liabilities of $200 or more. The cost of protecting enrollees against liabilities in excess of $200 would have been $59 per enrollee in 1978. A model was developed to estimate the additional cost in 1982 of fixing liability at selected limits. The added cost of the protection would be offset by reduced need to purchase "Medigap" policies. Alternatively, Medigap policies offering such catastrophic protection could be offered at lower premiums than present policies offering first-dollar insurance against coinsurance and deductibles.

Studies of Medicare Use Before Death

Contact: James Lubitz
Division of Beneficiary Studies

Description: These studies examine the use of Medicare services in the last years of life. This information is needed because of the large percentage of Medicare expenditures for enrollees in their last year and because of the interest in hospice care as an alternative kind of care for the terminally ill.

Status: Studies have shown that 28 percent of Medicare expenditures are for persons in their last year, that persons who die receive more than six times the reimbursements of other enrollees, and that expenditures in the last year are concentrated in the last few months. The results of these studies are scheduled for publication in Health, United States, 1983, the annual report from the Secretary of the Department of Health and Human Services to the President and Congress. Knowledge gained in these studies is being applied in the administration and evaluation of the hospice benefit. Work is underway to compute the legislatively mandated limit (cap) on reimbursements to hospices. In addition, data on Medicare reimbursements for the dying in conventional settings will be used as comparison data to evaluate the cost and utilization experience under the new hospice benefit. Finally, to expand the range of uses of data on use of Medicare benefits before death, efforts are being made to incorporate cause-of-death data into a sample of Medicare records. If the effort succeeds, Medicare use will be analyzed by cause of death. Comparisons will be made between Medicare hospital diagnosis and cause of death on death certificates.

Program Statistics Series Reports

Contact: Herbert Silverman
Division of Beneficiary Studies

Description: Based on administrative files and bills submitted for Medicare-covered services for program beneficiaries, statistical reports are issued on a regular basis that provide data on the number and characteristics of program beneficiaries; the number, distribution, and characteristics of providers certified to furnish services to Medicare enrollees; and the patterns of use of program benefits by beneficiaries. Use of benefits is examined by the characteristics of the persons using them, the providers furnishing the services, and the distribution of charges and reimbursements to beneficiaries and providers. The purpose of these reports is to show trends and to examine the factors that may be influencing those trends.

Status: The following reports are in the process of being published or have been sufficiently developed that usable data are available:

- "Medicare: Use of Short-Stay Hospitals by Aged and Disabled Inpatients, 1978"
- "Medicare: Use of Physicians' Services under the Supplementary Medical Insurance Program, 1975-1978"
- "Medicare: Participating Health Facilities, 1974-1979"
- "Medicare Summary: Use and Reimbursement by Person, 1979"
- "Medicare: Health Insurance for the Aged and Disabled, Reimbursement by State and County, 1980"
- "Medicare: Persons Enrolled in the Health Insurance Program, 1980"
- "Medicare: Use of Skilled Nursing Facility Services, 1979"
- "Medicare: Use of Hospital Outpatient Services, 1979"
- "Medicare: Use of Home Health Services, 1980"

The following reports are under development:

- "Medicare: Use of Skilled Nursing Facility Services, 1980"
- "Medicare: Use of Hospital Outpatient Services, 1981"
- "Medicare: Use of Short-Stay Hospitals by Aged and Disabled Inpatients, 1980"

Hospital Prospective Payment for Medicare

Contact: Allen Dobson
Office of Research

Description: This report responds to the Congressional mandate in Section 101 of Public Law 97-245 that the Secretary develop a proposal for Medicare payment to hospitals on a prospective basis. After discussing the role of prospective payment in containing hospital costs and reviewing State experience with hospital prospective payment demonstrations, a Medicare prospective payment proposal is described. The development of Diagnosis Related Groups (DRG's), the method for setting prospective payment system prices, is then explained. The Medicare Provider Analysis and Review (MEDPAR) data system is discussed. The report concludes with a discussion of incentives. A number of technical appendixes are included on State experiences, the Medicare case-mix index, severity of illness, statistical measures, MEDPAR, DRG's, and hospital wage indices.

Status: Delivered to Congress, December 1982.

Report on Hospital Prospective Payment Systems Mandated by Section 2173 of Public Law 97-35

Contact: William J. Sobaski
Division of Reimbursement Studies

Description: This report describes and analyzes alternative hospital prospective payment systems that might be adopted by States for Medicaid programs. Part I defines prospective payment and discusses technical design features that may be combined in various ways. Part II relates experiences of States to discuss a broad range of system design and implementation issues. Part III provides technical assistance information on specific issues such as case-mix, input price indexes, and volume adjustments, and it presents abstract descriptions of current State programs and a topical bibliography.

Status: Delivered to Congress, October 1982.

Foot Care Coverage Study

Contact: William J. Sobaski
Division of Reimbursement Studies

Description: Public Law 96-499, Section 958 (g), directs the Secretary to conduct a study involving a comprehensive analysis of the cost effects of alternative approaches to improving coverage under Title XVIII of the Social Security Act for the treatment of various types of foot conditions. The study has involved meetings and discussions with professional and Federal experts; staff reviews of literature and relevant statistical information; a Federal Register notice soliciting information and comments from the public; a survey of State Plans for Medical Assistance; an independent study by the Center for Health Services and Policy Research at Northwestern University; and

actuarial estimates of the costs of eliminating certain presently excluded or specially restricted types of expenses for treatment of foot conditions. The study will examine present Medicare benefits for the treatment of foot conditions as specified in the law and its implementing regulations and manuals. Possible ways for improving coverage will be identified, and the effects these changes could have upon beneficiary health status and on the pattern of sources now used for financing foot care treatment will be considered.

Status: The report is under development and should near completion by Fall 1983.

Registered Dietitians in Home Care

Contact: Mildred Corbin
Office of Research

Description: Section 958 of Public Law 96-499, the Omnibus Reconciliation Act of 1980, directs the Department of Health and Human Services to conduct a study of "the circumstances and conditions under which services furnished by registered dietitians should be covered as a home health benefit under Title XVIII of the Social Security Act." The study has three objectives:

- To assess Medicare beneficiaries' needs for direct clinical counseling by registered dietitians in the home.
- To explore alternative methods for coverage and reimbursement.
- To estimate utilization rates and costs for the alternative methods of coverage and reimbursement.

Status: The draft report is currently under review by the Health Care Financing Administration. It is due to be submitted to the Secretary of the Department of Health and Human Services by May 31, 1983.

Home Respiratory Therapy Services

Contact: Marni Hall
Division of Economic Analysis

Description: Section 958 of Public Law 96-499, the Omnibus Reconciliation Act of 1980, requires that the Department of Health and Human Services (DHHS) conduct "a study of the circumstances and conditions under which services furnished with respect to respiratory therapy should be covered as a home health benefit under Title XVIII of the Social Security Act." This study evaluates these issues and examines the present "state of the art" in respiratory therapy and the current availability of respiratory therapy services. It also examines the medical and economic ramifications of expanding Medicare benefits to include those home services provided by respiratory therapists.

Status: A draft of this report is being prepared. It is due to be submitted to the Secretary of the Department of Health and Human Services by August 31, 1983.

Medicare Health Maintenance Organization Additional Benefits

Contact: Korbin Liu
Division of Economic Analysis

Description: Section 114 of Public Law 97-248, the Tax Equity and Fiscal Responsibility Act of 1982 (TEFRA), requires that, to the extent a health maintenance organization's (HMO) Medicare payment exceeds its adjusted community rate under a risk-sharing contract, the HMO must use the savings to provide its Medicare members additional benefits or reduced cost sharing. Section 114 also requires that the Secretary conduct a study of the additional benefits provided under this provision. This study will report on the number of HMO's subject to the additional benefits requirement, and the nature of the benefits that HMO's choose to provide.

Status: The study depends on data that will be collected in 1984. This information will be compiled in a report due to Congress in August 1985.

Study of Unentitled End-Stage Renal Disease Patients

Contact: Korbin Liu
Division of Economic Analysis

Description: The Department estimated that in 1981 about 8,500 of the 55,000 End-Stage Renal Disease (ESRD) patients in the United States received dialysis treatments but were not entitled to Medicare benefits. Half of these unentitled patients were awaiting entitlement to the Medicare program. Blue Cross and other private insurers were the major sources of support (50 percent) for ESRD patients awaiting entitlement, while Medicaid was the primary payment source for another 27 percent. The other half of the unentitled patients were not awaiting entitlement because they were not working citizens of the United States (or their dependents) who had contributed to Federal social insurance programs. The major sources of support for 70 percent of these ESRD patients were public programs, that is, Medicaid, Veterans Administration, and State ESRD programs. An estimated 840 kidney transplants were performed on unentitled ESRD patients (about 17 percent of all the transplants performed) in 1981. Medicaid and State ESRD programs were the primary sources for these patients, both for those awaiting entitlement and those not awaiting entitlement. In addition, foreign governments were found to be important sources of payment for transplant patients not awaiting entitlement to Medicare. The costs of extending Medicare ESRD coverage to these unentitled patients were estimated. These costs ranged from $170 million in fiscal year 1984 to $290 million in fiscal year 1988. Since many unentitled ESRD patients were being supported by Federal programs other than Medicare, a decision to extend Medicare coverage to unentitled ESRD patients would reflect a transfer of payment of some of the additional costs from one Federal source to another. On the basis of these findings, the Department recommended that no legislative changes be considered at this time to extend Medicare ESRD coverage to currently unentitled patients with this condition.

Status: The report was completed in March 1983.

INDEX TO CONGRESSIONALLY MANDATED STUDIES

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